The EU and the Securitization of Pandemic Influenza

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DECLARATION

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

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Abstract

This thesis builds on the current literature on health security and on the European Union by examining the process of securitizing pandemic influenza at the level of the EU. It does so by two means: First, the thesis revisits securitization theory and the assumptions underpinning it in order to provide a revised theoretical framework that is more suited to analysing securitizing processes as they relate to pandemic influenza and the EU. Second, on the basis of this revised framework, the thesis offers a detailed empirical study of the process of securitization in this context. The thesis asks the following two questions: Has pandemic influenza been securitized at the level of the EU? What are the consequences for the role of the EU as a provider of health security?

The thesis broadly follows an externalist reading of securitization theory by arguing for the elevation of the importance of context and actor-audience disposition in accounting for processes of securitization in different empirical settings. On the basis of this, the thesis argues that it is possible to identify a process of securitizing pandemic influenza underway at EU level with political effect. This process of securitization has been spurred and propelled forward by a series of crisis events and has provided the basis for the expansion of EU competences and activities in providing for health security within the Union. The thesis demonstrates, however, that this process of securitization is a negotiated one and one marked by points of contestation throughout. Thus, while the thesis concludes that the process of securitizing pandemic influenza at the level of the EU has currently reached what can be considered a heightened stage, the extent of executive authority granted to the Commission in providing for health security within the Union remains limited.

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Table of Contents

INTRODUCTION: THE EU AND THE SECURITIZATION OF PANDEMIC INFLUENZA 7
INTRODUCTION 7
CENTRAL RESEARCH QUESTION AND THEORETICAL FRAMEWORK 9
STATE-OF-THE-ART 10
Health, security and International Relations 10
Health, security and the European Union 15
THEORETICAL FRAMEWORK 18
METHODOLOGY 20
Methodological challenges 23
STRUCTURE OF THE THESIS 26
CHAPTER 1: SECURITIZATION THEORY 30
INTRODUCTION 30
SECURITY, THE COPENHAGEN SCHOOL AND TWO STRANDS OF SECURITIZATION THINKING 32
THE SPEECH ACT AND LOCATING SECURITY MEANING 40
ACTOR-AUDIENCE DISPOSITION AND THE ROLE OF AUDIENCE IN THE SECURITIZATION PROCESS 52
CONCLUSION: A BLUEPRINT FOR SECURITIZATION THEORY'S EMPIRICAL APPLICATION 61
CHAPTER 2: PANDEMIC INFLUENZA IN CONTEXT: THE EVOLUTION OF A HEALTH SECURITY AGENDA IN THE EU AND INTERNATIONALLY 66
INTRODUCTION 66
HEALTH SECURITY AND THE INTERNATIONAL CONTEXT: RAISING THE ISSUE OF HEALTH ON THE INTERNATIONAL POLITICAL AGENDA 70
Health and (inter)national security 72
Health security and global public health 81
Health security as a component of human security 88
THE INSTITUTIONAL CONTEXT: THE EVOLUTION OF THE EU'S ROLE IN PUBLIC HEALTH 101
CONCLUSION 117
CHAPTER 3: THE PROCESS OF SECURITIZING PANDEMIC INFLUENZA AT THE LEVEL OF THE EU 121
INTRODUCTION 121
THE EU, ACTOR(S), AUDIENCE(S) AND SECURITIZING MOVES 124
THE SECURITIZATION OF PANDEMIC INFLUENZA AND THREE CRISIS EVENTS 134
The 2001 anthrax attacks and the creation of the Health Security Committee 137
The outbreak of SARS and the establishment of the ECDC 147
The re-emergence of H5N1 and the push for further EU-level coordination on pandemic preparedness 160
CONCLUSION 187
CHAPTER 4: THE 2009 INFLUENZA A(H1N1) PANDEMIC AND THE SECURITIZATION PROCESS 193
INTRODUCTION 193
THE 2009 INFLUENZA A(H1N1) PANDEMIC AND THE INITIAL EU RESPONSE 195

THE 2009 INFLUENZA A(H1N1) PANDEMIC AND THE REVIEW OF LESSONS LEARNED......219
CONCLUSION......232

CHAPTER 5: THE PROPOSAL FOR A DECISION ON SERIOUS CROSS-BORDER THREATS TO HEALTH 235

INTRODUCTION......235
THE COMMISSION PROPOSAL FOR A DECISION ON SERIOUS CROSS-BORDER THREATS TO HEALTH......238
The Commission's Proposal for a Decision on serious cross-border threats to health: Key Articles 246
FIRST READING OF THE COMMISSION PROPOSAL FOR A DECISION ON SERIOUS CROSS-BORDER THREATS TO HEALTH: THE CURRENT STATE OF PLAY......254
CONCLUSION......263

CONCLUSION: THE SECURITIZATION OF PANDEMIC INFLUENZA AT THE LEVEL OF THE EU: OUTCOMES AND FUTURE RESEARCH PROSPECTS......267

INTRODUCTION......267
SUMMARY OF KEY FINDINGS......269
OUTCOMES AND IMPLICATIONS......280
DIRECTIONS FOR FUTURE RESEARCH......284
PRIMARY SOURCES......286
SECONDARY SOURCES......299
INTERVIEWS......308

Introduction: The EU and the securitization of pandemic influenza

Introduction

The intersection between health and security has received increased attention in international politics over the course of the past 20 years. Since the end of the Cold War, the threat posed by communicable diseases in particular has emerged to feature with increased prominence on a number of foreign and security policy agendas. This has certainly been the case with regard to the threat of pandemic influenza. The legacy of the influenza pandemic of 1918 coupled with the risks associated with the circulation of such virus subtypes as the H5N1 avian influenza virus has focused both political attention and resources in a number of states on preparing for a pandemic eventuality. In the United Kingdom (UK), pandemic influenza has topped the 2008 and 2013 national risk registers as the highest risk facing the UK both in terms of relative impact and relative likelihood, surpassing the risk posed by a catastrophic terrorist attack.[1] The threat of pandemic has also been flagged in France's 2013 White Paper on Defence and National Security, while the link between disease and security has been a key feature of a number of the United States' security strategy documents since the turn of the millennium.[2] Recent years have also borne witness to a number of international collaborative arrangements aimed at countering the

[1] Cabinet Office. *National Risk Register* (London, Cabinet Office, 2008), p. 5; Cabinet Office. *National Risk Register of Civil Emergencies: 2013 edition* (London, Cabinet Office, 2013), p. 7.

[2] Le Ministère de la Défense. *Livre Blanc: Défense et Sécurité Nationale 2013* (Direction de l'information légale et administrative, Paris, 2013), p. 46; National Intelligence Council. *National Intelligence Estimate: The Global Infectious Disease Threat and its Implications for the United States*. NIE 99-17D (Washington, National Intelligence Council, 2000); National Intelligence Council. *Strategic Implications of Global Health*. ICA 2008-10D (Washington, National Intelligence Council, 2008); *National Security Strategy of the United States of America 2006*; *National Security Strategy of the United States of America 2010*.

challenges posed by disease circulation, such as the creation of the Global Health Security Initiative in 2001 and the entering into force of the revised International Health Regulations in 2005. The recent identification of a new A(H7N9) avian influenza virus and the detection of human infections, moreover, along with the identification of the novel Middle East respiratory syndrome coronavirus (MERS-CoV) suggest that the link between security and health will continue to hold bearing for international politics in years to come.

Amongst those actors who have expressed an increased preoccupation with the link between security and health over the course of the millennium is the European Union (EU). Since the entering into force of the Maastricht Treaty in 1993, the EU has gained increased competences in providing for public health protection within the Union and has expressed aspirations of becoming a prominent actor in the global public health arena.[3] A key feature of this evolving role for the EU has been a concern with the protection of the European space from the emergence and spread of such highly virulent pathogens as an influenza virus with pandemic potential. Yet, despite the increase in EU activity in this domain, little scholarship has been done on the role of the EU in providing for health security. Indeed, as Erik Brattberg and Mark Rhinard have noted, the EU has often been 'neglected in governance studies of global health threats.'[4]

The aim of this thesis, then, is to contribute to the current literature on health security and on the European Union by examining whether pandemic influenza has come to be recognised as a security threat at the level of the EU and the consequences this bears for the role of the EU in managing such transboundary health challenges as an influenza

[3] See European Commission. *Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions: The EU Role in Global Health*. COM(2010) 128 final. Brussels, 31.3.2010.
[4] Brattberg, E. & M. Rhinard. 'Multilevel Governance and Complex Threats: The Case of Pandemic Preparedness in the European Union and the United States', *Global Health Governance* 1(2011), p. 2.

pandemic. In so doing, the thesis builds on current scholarship on the securitization of health by drawing on securitization theory to account for the process of constituting pandemic influenza as a security threat at Union level. Pandemic influenza has been chosen as a case study for two reasons: First, the cyclical nature of pandemic influenza and its potential for high rates of morbidity and mortality in a relatively short span of time make it an ideal representative of the threat associated with disease emergence more generally. Second, pandemic influenza has dominated global discussions on health security at the same time as the EU has been developing competences in the domain of public health. Pandemic influenza thus provides a means of examining the relationship between the rise of health security internationally over the course of the past 20 years and the concomitant rise of an EU role in public health. As the thesis is concerned with accounting for the emerging role of the EU as a health security provider, moreover, the focus of analysis falls on the interrelation between the EU institutions in the process of securitizing pandemic influenza and not on the dynamics within and between individual Member States themselves.

Central research question and theoretical framework

The central research question informing this thesis is thereby as follows: Has pandemic influenza been securitized at the level of the EU? This leads to the subsequent question, what are the consequences for the role of the EU as a provider of health security? As a means of answering these questions, the thesis begins by revisiting the Copenhagen School's theory of securitization. Indeed, while securitization theory provides a theoretically useful starting point in unpacking the process of constituting pandemic influenza as a matter of security, as is made evident throughout the course of this study, it does not provide the

tools necessary to account for securitizing dynamics as they pertain to pandemic influenza and the EU. As such, the thesis begins by outlining a revised version of securitization theory as a means of providing a more useful framework for analysing processes of securitization both as they pertain to the EU as the referent object of security and as they pertain to pandemic influenza as a particular threat subject. On the basis of this revised framework, the remainder of the thesis offers a detailed account of the process of securitizing pandemic influenza at the level of the EU. In so doing, the thesis makes an original and necessary contribution to current scholarship on the security-health nexus on two fronts: First, the thesis provides a detailed empirical case study of the securitization of pandemic influenza; and second, the thesis offers insight into the evolving role of the EU as a health security provider and the securitizing dynamics associated with it. Both of these areas are areas in which scholarship to date remains limited.

State-of-the-art

The thesis stands at the crossroads of two general bodies of literature: literature focused on the intersection between health and security and in particular, the securitization of health; and literature on the European Union and its activities in the fields of health and security.

Health, security and International Relations

Within the discipline of International Relations (IR), scholarly debates on the link between health and security have broadly grown out of two lines of inquiry: (1) an empirical/positivist line that has focused on the link between security and health; and (2) a

normative/cost-benefit engagement with the security-health nexus. While the former has included both quantitative and qualitative research studies focused on determining or predicting the impact particular health challenges carry for human, national and international security alike, the latter has primarily been concerned with the limitations, advantages and disadvantages that speaking of health in the language of security carries for the governance of health and disease.

Scholarship falling into the first line of inquiry has thereby primarily focused on demonstrating the impact that the prevalence of disease carries for experiences of insecurity at individual or community levels, as well as for state capacity, national and international economic and political stability, and for peacekeeping forces and the armed forces of the state.[5] While a significant portion of this work has been concerned with the security implications of HIV/AIDS in particular, a number of authors have also directed attention to the threat that highly virulent pathogens such as an influenza virus with pandemic potential carry for national and international security alike. A typical example is Michael T. Osterholm's 2005 article, 'Preparing for the Next Pandemic', in which Osterholm

[5] See, for example, Altman, D. 'AIDS and Security', *International* Relations 17(2003), pp. 417-27; Elbe, S. 'HIV/AIDS and the Changing Landscape of War in Africa', *International* Security 27(2002), pp. 159-77; Elbe, S. 'HIV/AIDS: A Human Security Challenge for the 21st Century', *The Whitehead Journal of Diplomacy and International Relations* VI(2006), pp. 101-13; Enemark, C. 'Pandemic pending', *Australian Journal of International Affairs* 60(2006), pp. 43-9; Garrett, L. 'The Return of Infectious Disease', *Foreign Affairs* 75(1996), pp. 66-79; Heymann, D. L. 'The Evolving Infectious Disease Threat: implications for national and global security', *Journal of Human Development* 4(2003), pp. 191-207; Huang, Y. 'In-Flew-Enza: Pandemic Influenza and Its Security Implications', in *Innovation in Global Health Governance*, edited by Andrew F. Cooper & Jon J. Kirton (Farnham, Ashgate, 2009), pp. 130-52; Ostergard, Jr, R. L. 'Politics in the hot zone: AIDS and national security in Africa', *Third World* Quarterly 23(2002), pp. 333-350; Osterholm, M. T. 'Preparing for the next pandemic', *Foreign Affairs* 84(2005), pp. 24-37; Osterholm, M. T. 'Unprepared for a Pandemic', *Foreign Affairs* 86(2007), pp. 47-57; Palmore, J. 'A clear and present danger to international security: Highly Pathogenic Avian Influenza', *Defense and Security Analysis* 22(2006), pp. 111-21; Price-Smith, A. T. 'Ghosts of Kigali: Infectious Disease and global stability at the turn of the century', *International Journal* 54(1999), pp. 426-42; Price-Smith, A. T. *Contagion and Chaos: Disease, Ecology, and National Security in the Era of Globalization* (Cambridge, MA & London, The MIT Press, 2009); Price-Smith, A. T. *The Health of Nations: Infectious Disease, Environmental Change, and Their Effects on National Security and Development* (Cambridge, MA, The MIT Press, 2002); Schoeman, J. C. 'Disease and security: The effect of emerging and re-emerging diseases', *Medicine, Conflict and Survival* 16(2000), pp. 302-9; Singer, P.W. 'AIDS and International Security', *Survival* 44(2002), pp. 145-58.

makes the case for pandemic preparedness planning on the basis of the argument that if unaddressed, the next influenza pandemic could not only lead to high rates of morbidity and mortality, but also destabilize the economic and political stability of the state, leading in the worst case scenario to the collapse of the global economy.[6] In a similar vein, although presenting a slightly more nuanced analysis, Yanzhong Huang has sought to demonstrate the security potential of an influenza pandemic on the basis of the negative consequences that a pandemic could carry for the global economy, socio-political stability, military security and international stability depending on the severity of the virus and its international context.[7] A key feature of this literature has been the recurrent nature of influenza pandemics, the influenza pandemic of 1918 often cited as an example of the degree of devastation that an influenza pandemic could cause.[8]

A growing body of work, however, has also begun to revisit some of the initial claims made as to the link between security and health. Focusing on the (inter)national security implications of HIV/AIDS in particular, a number of scholars have demonstrated that the links between disease prevalence and security are more complex, nuanced and tenuous than initially maintained.[9] Both Colin McInnes and Susan Peterson, for example, have argued that despite the increased focus on the national security implications of disease in academic and policy circles, there remains a paucity of evidence convincingly demonstrating

[6] Osterholm, 'Preparing for the Next Pandemic', pp. 29-30.
[7] Huang, 'In-Flew-Enza'.
[8] See, for example, Enemark, 'Is Pandemic Flu a Security Threat?', p. 193; Enemark, 'Pandemic Pending', p. 45; Huang, 'In-Flew-Enza', pp. 130-4; Price-Smith, *Contagion and Chaos*, pp. 57-87; Osterholm, 'Unprepared for a Pandemic', p. 48.
[9] See, for example, Barnett, T. & G. Prins. 'HIV/AIDS and security: fact, fiction and evidence – a report to UNAIDS', *International Affairs* 82(2006), pp. 359-68; de Waal, A. 'Reframing governance, security and conflict in the light of HIV/AIDS: A synthesis of findings from the AIDS, security and conflict initiative', *Social Science and Medicine* 70(2010), pp. 114-120; Feldbaum, H., K. Lee & P. Patel. 'The National Security Implication of HIV/AIDS', *PLoS Medicine* 3(2006), pp. 0774-0778; McInnes, C. & S. Rushton. 'HIV, AIDS and security: where are we now?', *International Affairs* 86(2010), pp. 225-245; Whiteside, A., A. de Waal & T. Gebre-Tensae. 'AIDS, Security and the Military in Africa: A Sober Appraisal', *African Affairs* 105(2006), pp. 201-18.

the direct nature of this link, particularly in the context of Western industrialized states.[10] McInnes and Kelley Lee, moreover, have noted that to date, 'the causal relationship between an adverse health effect and international stability is questionable and/or the empirical evidence to support the claim is suspect or missing.'[11]

The apparent ill-fit between global health challenges and the language of (inter)national security has led some scholars to advocate for a more holistic approach to the security-health nexus based on the promotion of human security.[12] However, the link between health and (inter)national security has also been taken up in a second line of inquiry that has primarily focused on the utility and suitability of engaging with health as a matter of security. This second line of inquiry has taken a broad constructivist approach to the study of the intersection of security and health, drawing particularly from securitization theory either explicitly or implicitly, and focusing on the performative function of labelling particular health issues as security concerns. Studies have explored whether or under what conditions health should be engaged with as a matter of security, and focused on the advantages and disadvantages of a security framing for health outcomes.[13]

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[10] McInnes, C. 'National Security and Global Health Governance', in *Global Health Governance: Crises, Institutions and Political Economy*, edited by Adrian Kay and Owain Williams (Houndmills, Palgrave MacMillan, 2009), pp. 42-59; Peterson, S. 'Epidemic Disease and National Security', *Security Studies* 12(2002), pp. 43-81.

[11] McInnes, C. & K. Lee. *Global Health and International Relations* (Cambridge & Malden, MA, Polity, 2012), p. 149.

[12] See, for example, Caballero-Anthony, M. 'Combating Infectious Diseases in East Asia: Securitization and Global Public Goods for Health and Human Security', *Journal of International Affairs* 59(2006), pp. 105-27; Caballero-Anthony, M. 'Non-traditional security and infectious diseases in ASEAN: going beyond the rhetoric of securitization to deeper institutionalization', *The Pacific Review* 21(2008), pp. 507-25; Gutlove, P. & G. Thompson. 'Human security: Expanding the scope of public health', *Medicine, Conflict and Survival* 19(2003), pp. 17-34; Maclean, S. J. 'Microbes, Mad Cows and Militaries: Exploring the Links Between Health and Security', *Security Dialogue* 39(2008), pp. 475-94; McInnes, C. 'Looking beyond the national interest: reconstructing the debate on health and foreign policy', *Medical Journal of Australia* 180(2004), pp. 168-70.

[13] See, for example, Elbe, S. 'AIDS, Security, Biopolitics', *International Relations* 19(2005), pp. 403-19; Elbe, S. 'Risking Lives: AIDS, Security and Three Concepts of Risk', *Security Dialogue* 39(2008), pp. 177-98; Elbe, S. 'Should HIV/AIDS Be Securitized? The Ethical Dilemmas of Linking HIV/AIDS and Security', *International Studies Quarterly* 50(2006), pp. 119-44; Elbe, S. *Virus Alert: Security, Governmentality and the AIDS* Pandemic (New York, Columbia University Press, 2009); Enemark, C. 'Is Pandemic Flu a Security Threat', *Survival* 51(2009), pp.

In his assessment of the risks and benefits of securitizing pandemic influenza, for example, Christian Enemark has argued that the elements of speed and dread associated with an influenza outbreak and the resultant societal disruption that a pandemic could cause independent of potential rates of morbidity and mortality make pandemic influenza amenable to securitization.[14] In a similar vein, Colin McInnes has identified three criteria for determining which health issues are likely to carry the potential for securitization: the severity of the threat posed by the issue; the geographical reach of the issue; and the recognised legitimacy of the issue as a security concern.[15] In contrast, focusing on avian influenza in particular, Jeremy Youde has warned against a security framing on the basis that it not only encourages inappropriate responses, but also draws attention away from more immediate public health needs in many countries and risks reinforcing distinctions between the developed and the developing world.[16]

Taken together, these two bodies of literature have provided insight into the securitization of disease and health, exposing the inconsistencies between empirical findings and particular security claims, highlighting the dangers and benefits of securitizing particular health concerns, as well as underscoring the limitations that securitizing certain diseases carry for the provision of public health more broadly. However, as Melissa Curley and Jonathan Herington have noted, while the literature on the securitization of health has

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191-214; Enemark, C. *Disease and Security: Natural Plagues and Biological Weapons in East Asia* (Abingdon, Oxon & New York, Routledge, 2007); Feldbaum, H., K. Lee & J. Michaud. 'Global Health and Foreign Policy', *Epidemiologic Reviews* 32(2010), pp.6-7; Feldbaum, H., P. Patel, E. Sondorp & K. Lee. 'Global health and national security: the need for critical engagement', *Medicine, Conflict and Survival* 22(2006), pp. 192-8; Katz, R. & D. A. Singer. 'Health and security in foreign policy', *Bulletin of the World Health Organization* 85(2007), pp. 233-4; McInnes, C. 'HIV/AIDS and security', *International Affairs* 82(2006), pp. 315-26; Youde, J. 'Who's Afraid of a Chicken? Securitization and Avian Flu', *Democracy and Security* 4(2008), pp. 148-69; Youde, J. *Global Health Governance* (Cambridge & Malden, MA, Polity, 2012), pp. 132-43.

[14] Enemark, 'Is Pandemic Flu a Security Threat?', pp. 196-8. See also Enemark, *Disease and Security.*

[15] McInnes, C. 'Health and Security Studies', in *Health, Foreign Policy and Security: Towards a Conceptual Framework for Research and Policy*, edited by Alan Ingram (London, The Nuffield Trust, 2004), pp. 54-5.

[16] Youde, 'Who's Afraid of a Chicken?', p. 149.

provided ‘a number of theoretical deconstructions of the link between security and health, empirical analyses of key case studies remain scarce.’[17] An emerging number of scholars have therefore begun to shift the debate away from the question of whether certain health issues should be securitized to examine the impact and consequences of the securitization process itself.[18] These works have taken their starting point in the recognition that the securitization of particular health issue is neither a monocausal nor a monolithic process, but one that is complex, uneven in application and contextually situated.[19] The focus of these studies has thus been on the process by or conditions in which certain health challenges have been subject to securitization, the degree of success or failure of these attempts, and the consequences of this.

This thesis is situated within this latter body of work and aims to contribute to current understandings of the securitization of health by unpacking the process of securitizing pandemic influenza in the context of the EU.

Health, security and the European Union

To date, the literature on the EU’s role as a health security provider is limited. On the one hand, the majority of literature focused on the role of the EU in providing for security has primarily approached security in conceptually narrow terms, directing attention to the

[17] Curley, M. & J. Herington. ‘The securitisation of avian influenza: international discourses and domestic politics in Asia’, *Review of International Studies* 37(2011), p. 142.
[18] See, for example, Abraham, T. ‘The Chronicle of a Disease Foretold: Pandemic H1N1 and the Construction of a Global Health Security Threat’, *Political Studies* 59(2011), pp. 797-812; Curley & Herington, ‘The securitisation of avian influenza’; Herington, J. ‘Securitization of infectious diseases in Vietnam: the cases of HIV and avian influenza’, *Health Policy and Planning* 25(2010), pp. 467-75; Leboeuf, A. & E. Broughton. *Securitization of Health and Environmental Issues: Process and Effects. A Research Outline* (Paris & Brussels, IFRI, 2008); McInnes, C. & S. Rushton. ‘HIV/AIDS and securitization theory’, *European Journal of International Relations* 0(2011), pp. 1-24.
[19] Curley & Herington, ‘The securitisation of avian influenza’, p. 2; Leboeuf & Broughton, *Securitization of Health and Environmental Issues*, p. 15; McInnes & Rushton, ‘HIV/AIDS and securitization theory’, p. 3.

Common Foreign and Security Policy (CFSP) pillar in particular, or in the case of such non-conventional challenges as transnational organised crime and terrorism, the Police and Judicial Cooperation in Criminal Matters (PJCC) pillar, formerly known as Justice and Home Affairs (JHA). As Kamil Zwolski has noted, the effect has been that 'the literature on the EU as a security actor does not entirely reflect the development of the security concept as found in post-Cold War security studies literature' with the consequence that the EU is perceived as 'less of a security actor than it actually is.'[20] As a result, securitizing dynamics that may be evidenced in such sectors as public health have largely gone unaccounted for.

On the other hand, the literature on the EU's involvement in the domain of public health has primarily been concerned with various political or legal features of the Europeanization of public health and has largely overlooked the security dimension of these developments. This literature has focused on different aspects of the governance of health within the Union, including the driving forces behind the evolution of communicable disease control arrangements in the Union and the tensions that have emerged from them, as well as the role afforded to the EU as a unified actor in the domain of health.[21] However, this

[20] Zwolski, K. 'The European Union as a Security Actor: Moving Beyond the Second Pillar', *Journal of Contemporary European Research* 5(2009), pp. 82-3.

[21] See, for example, Elliott, H. A., D. K. Jones & S. L. Greer. 'Mapping Communicable Disease Control in the European Union', *Journal of Health Politics, Policy and Law* 37(2012), pp. 933-52; Fox, D. M. 'The Governance of Disease Control in Europe', *Journal of Health Politics, Policy and Law* 37(2012), pp. 1119-30; Greer, S. L. & M. Mätzke. 'Bacteria without Borders: Communicable Disease Politics in Europe', *Journal of Health Politics, Policy and Law* 37(2012), pp. 885-912; Greer, S. L. 'The European Centre for Disease Prevention and Control: Hub or Hollow Core?', *Journal of Health Politics, Policy and Law* 37(2012), pp. 999-1028; Greer, S. L. 'Uninvited Europeanization: neofunctionalism and the EU in health policy', *Journal of European Public Policy* 13(2006), pp. 134-52; Guigner, S. *Health: A Vital issue for Europe* (Paris, Notre Europe, 2009); Hervey, T. 'The Role of the European Court of Justice in the Europeanization of Communicable Disease Control: Driver or Irrelevance?', *Journal of Health Politics, Policy and Law* 37(2012), pp. 975-98; Jacobson, P. D. 'The Role of Networks in the European Union Public Health Experience', *Journal of Health Politics, Policy and Law* 37(2012), pp. 1047-53; Liverani, M. & R. Coker. 'Protecting Europe from Diseases: From the International Sanitary Conferences to the ECDC', *Journal of Health Politics, Policy and Law* 37(2012), pp. 913-32; Liverani, M., P. Hanvoravongchai & R. J. Coker. 'Communicable diseases and governance: A tale of two regions', *Global Public Health* 7(2012), pp. 574-87; Martin, R. & A. Conseil. 'Public Health Policy and Law for Pandemic Influenza: A Case for European Harmonization?', *Journal of Health Politics, Policy and Law* 37(2012), pp. 1089-1108; Martin, R. 'The role of law in pandemic influenza preparedness in Europe', *Public Health* 123(2009), pp. 247-54; Mätzke, M. 'Institutional

work has yet to interrogate in detail how these developments may be linked to a changing security environment and a concomitant shifting role of the EU as a security provider.

Where health has been addressed from the standpoint of security in the literature on the EU, it has either been subsumed in the literature on transboundary crisis management or addressed in relation to the threat of bioterrorism specifically.[22] This work, however, has for the most part not explicitly engaged with the security dynamics associated with such specific health challenges as pandemic influenza and the implications these dynamics bear for the EU. That is to say, this body of literature has not explicitly discussed how or why health is a security issue for the EU. An exception is the article published by Erik Brattberg and Mark Rhinard that draws on securitization theory in comparing the EU's and the United States' responses to influenza pandemics. The article asserts that the increased use of securitizing rhetoric following the appearance of the H5N1 and H1N1 influenza viruses and the subsequent creation of new policies, structures and operational capacities demonstrates that 'securitizing a public policy problem can increase political leverage over administrative processes of implementation.'[23] However, while Brattberg and Rhinard conclude on the basis of comparing securitizing rhetoric with the implementation of policy

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Resources for Communicable Disease Control in Europe: Diversity across Time and Place', *Journal of Health Politics, Policy and Law* 37 (2012), pp. 965-74; Mossialos, E., G. Permanand, R. Baeten & T. K. Hervey (eds). *Health Systems Governance in Europe: The Role of European Union Law and Policy* (Cambridge, Cambridge University Press, 2010); Reintjes, R. 'Variation Matters: Epidemiological Surveillance in Europe', *Journal of Health Politics, Policy and Law* 37(2012), pp. 953-63; Steffen, M. (ed.) *Health Governance in Europe: Issues, challenges and theories* (Abingdon, Oxon & New York, Routledge, 2005); Steffen, M. 'The Europeanization of Public Health: How Does it Work? The Seminal Role of the AIDS Case', *Journal of Health Politics, Policy and Law* 37(2012), pp. 1055-87; Taylor, R. 'Public Health in a Transnational Context: Explaining Europe's Role', *Journal of Health Politics, Policy and Law* 37(2012), pp. 1109-18.

[22] See, for example, Boin, A. & M. Rhinard. 'Managing Transboundary Crises: What Role for the European Union?', *International Studies Review* 10(2008), pp. 1-26; Boin, A., M. Busuioc & M. Groenleer. *Building Joint Capacity: The Role of European Agencies in the Management of Transboundary Crises*. Jerusalem Papers in Regulation and Governance, Working Paper No 36, August 2011; Boin, A., M. Ekengren & M. Rhinard. 'Protecting the Union: Analysing an Emerging Policy Space', *Journal of European Integration* 28(2006), pp. 405-21; Kuhlau, F. *Countering Bio-threats: EU Instruments for Managing Biological Materials, Technology and Knowledge*. SIPRI Policy Paper No. 19 (Stockholm, SIPRI, 2007).

[23] Brattberg & Rhinard, 'Multilevel Governance and Complex Threats', p. 1.

tools and instruments that pandemic influenza has been securitized in the EU context, the article reveals little about the securitization process itself and offers a cursory engagement with securitization theory.

This thesis thereby contributes to current literature on the EU, health and security by providing an empirical account of the process of securitizing pandemic influenza at the level of the EU as a means of assessing whether or not pandemic influenza can in fact be considered securitized in this context and the consequences this bears for the evolving role of the EU in the public health domain. In so doing, the thesis seeks to bridge the health and security literature on the EU to account for the emerging role of the EU as a health security provider.

Theoretical framework

The Copenhagen School's securitization theory is used as the framework guiding the empirical study in this thesis for three reasons: First, the ontological underpinnings of securitization theory provide an entry point for considering how certain health challenges have come to be recognised as security concerns over others. As securitization theory recognises threats to security as socially constructed, the theory enables a consideration of how such issues as pandemic influenza are placed on the security agenda independent of empirical evidence to support the security claim. Second, in a similar vein, securitization theory offers a means of accounting for the broadening of the security agenda at EU level into domains that are not traditionally associated with security and defence. Third, given the prominence of securitization theory as a point of reference in analyses of the security-health nexus, approaching the thesis from the standpoint of securitization theory enables the

thesis to directly engage with and contribute to a significant part of the literature on the subject-matter to date.

Securitization theory maintains that security is socially constructed and intersubjectively established. It differs from positivist approaches to the study of security by placing emphasis on the causal influence of ideas over material conditions in determining security meaning. The aim of the theory, according to the Copenhagen School, is to 'provide a classification of what is and what is not a security issue, to explain how issues become securitized, and to locate the relevant security dynamics of different types of security on levels ranging from local through regional to global.'[24] Securitization theory thus differs from a Critical Security Studies approach to security in that it does not attempt to reconceptualize the statist meaning of security, but rather seeks to analyse the dynamics of security within a recognised set of sedimented structures.[25] Indeed, whereas Critical Security Studies advocates an alternative approach to security based on the notion of emancipation, for Ole Wæver, to approach security outside the historically established notion of state security is to approach security 'via another language game.'[26] By treating security as a discursive act, then, the Copenhagen School's theory of securitization attempts to account for the broadening of the security agenda while maintaining the conceptual specificity of the term. In this respect, securitization theory also differs from a realist approach to the study of

[24] Buzan, B., O. Wæver & J. de Wilde. *Security: A New Framework for Analysis* (Boulder & London, Lynne Reinner, 1998), p. 1.

[25] Buzan et al., *Security*, p. 35.

[26] Wæver, O. 'Securitization and Desecuritization', in *On Security*, edited by Ronnie D. Lipschutz (New York, Columbia University Press, 1995), p. 51. For an overview of the Critical Security Studies approach, see Booth, K. *Theory of World Security* (Cambridge, Cambridge University Press, 2007).

security which, with its emphasis on military threats to the state, is unlikely to recognise issues as security concerns if they do not carry military significance.[27]

The concept of securitization, then, provides a means of analysing the constitution of such health challenges as an influenza pandemic as security concerns given that, as Colin McInnes and Simon Rushton have noted, 'the positioning of particular health issues on the security agenda appears to be to a great extent unrelated to measures of morbidity and mortality.'[28] Additionally, it provides a mechanism for accounting for the expansion of the security agenda into new sectors at EU level through its focus on the discursive constitution of threat.

Methodology

The methodology employed for the purposes of this thesis has been based on the triangulation of academic material, official statements and documents, and elite semi-structured interviews. The academic material has predominantly been drawn from IR literature on health, security and the EU, but has also included engagement with relevant material from the fields of public health and health policy. Relevant literature has been identified through the employment of key word searches in academic search engines and through academic citations.

[27] Andrew T. Price-Smith and Yanzhong Huang have argued, however, that a classical (republican) realist perspective would recognise 'epidemic disease as a distinct threat to the material and perhaps ideational interests of the sovereign state, through its destruction and debilitation of the populace, disruption of institutions and governance, and generation of fear that erodes prosperity.' Price-Smith, A. T. & Y. Huang. 'Epidemic of Fear: SARS and the Political Economy of Contagion', in *Innovations in Global Health Governance*, edited by Andrew F. Cooper & Jon K. Kirton (Farnham, Ashgate, 2009), p. 25.
[28] McInnes & Rushton, 'HIV/AIDS and Securitization Theory', p. 2.

The analysis of official statements and documents has primarily focused on material from EU bodies – the European Commission, the Council of the European Union, the European Council and the European Parliament. This has included, for example, Commission Communications, Commission Staff Working Documents, legislative proposals, Council Conclusions, European Parliament Recommendations and parliamentary committee reports. Speeches from the various Commissioners for Health and Consumer Affairs (DG SANCO) over the years have also been drawn upon, as have reports from the European Centre for Disease Prevention and Control (ECDC), and documents from relevant conferences or meetings where available. Where appropriate, official documents from other international actors have also been consulted, such as documents from the World Health Organization (WHO), the Global Health Security Initiative (GHSI) and the Council of Europe. In all cases, these documents have been freely available from the websites of the relevant institutions and organizations, from the Official Journal of the European Union and from the European Union's press office. The purpose of analysing these documents has been three-fold: First, to identify how pandemic influenza and other outbreak events covered in the timeframe of this thesis are being framed both by the institutions of the EU and by prominent actors internationally, such as the WHO; second, to identify and trace the development of policies formulated in response to the health challenges identified; and third, to identify points of contestation that have emerged throughout this process, to the extent that they are reflected in the documents themselves.

The analysis of official statements and documents has been supplemented by semi-structured interviews with elites from the Commission, the Council and the Parliament, as well as from the ECDC, the WHO Regional Office for Europe, Member State delegations to

the EU, and select Member States. The purpose of the interviews was not only to gain insight into aspects of the policy-making process that were not reflected in the EU documents themselves, but also to provide points of clarification on gaps in knowledge identified in the process of tracing the course of events at EU level. As official documents only tend to reflect the official positions of the EU institutions and not the internal processes leading up to those positions, conducting elite interviews provided a means of gaining insight into such issues as perceptions as to the threat posed by pandemic influenza and the reason behind particular courses of action. The interviews thereby assisted in the interpretation of official documents. They also provided a means of identifying documents deemed important for the purposes of the thesis and thereby a means of ensuring that all relevant documents were accounted for in the final analysis.

The interviews were conducted in two rounds. The first round took place between 1 June and 1 July 2011, while the second round was conducted a year later between the dates of 23 May and 14 June 2012. All interviewees were asked a series of questions that fell under three categories: the perception of the threat posed by pandemic influenza; the identification of key actors and events; and the identification of points of contestation or agreement in the process of developing policy. The second round of interviews provided an opportunity to expand the initial pool of contacts from the first round, to clarify gaps in knowledge identified throughout the course of the research, and to receive an update on EU level developments, particularly as they pertained to the introduction of the Commission Proposal for a Decision on serious cross-border threats to health. The informed consent was assured by all interviewees through an introductory letter sent to all potential participants explaining the nature of the project and the purpose of the interviews. Additionally, prior to

each interview, the interviewee was asked to fill out a consent form indicating that they understood the purpose of the research and that they agreed to participate, and indicating whether they would allow the interview to be recorded and whether the material from the interview could be quoted in any subsequent analysis. All interviews were recorded unless otherwise requested. In those instances where interviewees did not wish to be recorded, notes were taken by hand. Names of interviewees have been used throughout the analysis unless otherwise specified. The interviews were subsequently transcribed and stored securely on a personal computer.

Methodological challenges

The methodological challenges posed by the research have primarily concerned issues of access and issues of reliability, validity and representativeness. With respect to the former, while the majority of official documents from the EU institutions are readily available on the Internet, those documents that relate to decision-making processes leading up to official positions are more difficult to account for, such as documents from meetings between the Commission, the Council and the various expert and advisory bodies that assist them in the policy-making process. While these expert and advisory groups clearly hold sway in determining the direction of Union policy, their interactions are not highly publicized and therefore difficult to trace. This shortcoming was accounted for in part by tracing decision-making processes through the citations of previous documents, events and meetings in the official documents from the various EU institutions themselves. These citations proved useful in developing a timeline of events and in identifying key documents and decisions taken. Where information has not been easily available, the analysis of official documents

has been supplemented by secondary literature, including articles from *Eurosurveillance* and other academic sources that have addressed various aspects of EU public health policy. These sources were used to gain additional information on policy developments as a means of both completing and corroborating information found in official documents. The elite interviews provided an additional means of supplementing and corroborating initial findings.

The issue of access, however, also presented challenges with respect to the interviews themselves. These challenges concerned on the one hand, identifying the relevant individuals to talk to in the EU and on the other hand, gaining access to them. The EU Directory provided an initial means of identifying potential interviewees. However, the Directory only provides the names of individuals who currently head various units within the EU institutions. Gaining access to individuals within these various units was therefore dependent on successfully making contact with the heads of units themselves. Moreover, given the high turnover of individuals in the EU institutions, it was not always possible to identify or meet with people who held particular positions previously. This 'gatekeeping' meant that the process of identifying, contacting and setting up meetings with relevant individuals was longer than initially anticipated and in some instances ran up against time constraints. This problem was ameliorated in part by asking interviewees to recommend contacts and by conducting a second round of interviews. Ultimately, however, it was not always possible to attain interviews with relevant individuals.

The issue of access was a particular problem with Members of the European Parliament (MEPs). Although interviews were held with a small handful of MEPs from the Environment, Public Health and Food Safety (ENVI) Committee – the Committee primarily

responsible for matters pertaining to public health – it was not possible to get interviews with the Rapporteurs of relevant parliamentary committee reports. This was either due to lack of response, lack of time on the part of the MEP, or poor timing. In a similar vein, while interviews were held with individuals from a number of Member State delegations to the EU, it was not possible to get interviews at all of the Member State delegations. This was particularly the case with a number of the Member State delegations from the eastern European region. While in some instances this had to do with a lack of response or a lack of time, in other instances Member State representatives did not have the authorization to hold interviews as a general point of policy. While it would have been preferable to carry out additional interviews in both cases, the inability to attain interviews in these instances does not ultimately compromise the integrity of the research findings. In the case of the Parliament, the position of the Parliament was readily discernible in the parliamentary reports themselves and thus could still be accounted for. In the case of the Member State delegations, while it would have been interesting to interview individuals from a broader spectrum of Member States as a means of pulling out potential differences in perceptions or experiences in more detail, as the analysis undertaken in this thesis focuses on the Council as a unit in and of itself, the general position of the Council on key issues and points of deliberation that have arisen in the Council could still be discerned from those interviews that were conducted and from publically available documents.

The issues of reliability, validity and representativeness arose from the points concerning access raised above. The inability to consistently and clearly discern the decision-making process ran the risk of misrepresenting events as they actually occurred. In a similar vein, the high turnover of individuals working in the various EU institutions meant

that oftentimes institutional memory was limited. While interviewees spoke from the standpoint of their official positions, the reliance on memory in recounting events necessarily raises the methodological concern with how the quality of information gained from interviews is to be assessed. In both instances these challenges were overcome to the extent possible through the use of triangulation. By comparing the data gathered from official documents with the information from the elite interviews and secondary sources, it was possible to validate the general course of events and responses to them.

Structure of the thesis

The thesis is structured into two parts: the theoretical framework and the empirical analysis. Chapter one introduces securitization theory as the theoretical framework guiding the analysis that follows in subsequent chapters. The chapter begins by outlining the Copenhagen School's theory of securitization and the assumptions underpinning it, before examining those elements of the theory that this thesis argues require revisiting for the purposes of this study – namely, the criterion of exceptionality and the role of the speech act in locating security meaning, and the disposition of actor and audience in the securitization process. The chapter demonstrates the importance of context in accounting for processes of securitization, both as it pertains to the setting in which securitizing dynamics take place and as it pertains to the role of external events in influencing the securitization process. On the basis of these insights, the chapter presents a reworked framework for analysis that is used to inform the empirical investigation undertaken in subsequent chapters. Chapters two, three, four and five focus on various aspects of the case study itself.

Chapter two picks up on the relevance of context argued in chapter one by focusing on the contextual backdrop informing the process of securitizing pandemic influenza at the level of the EU. The chapter is divided into two parts: The first part focuses on the evolution of the concept of health security in international engagements with health and the major events that have shaped the rise of the notion of health security internationally. The second part of the chapter locates the evolution of an EU role in public health within this broader international context and outlines the major institutional developments that provide the basis for the EU's engagements in the field of public health. The chapter thereby sets up the background for examining EU-level engagements with pandemic influenza through the lens of securitization.

Chapter three focuses specifically on the evolution of an EU health security agenda and the concomitant process of securitizing pandemic influenza over the course of the past 20 years. The chapter begins by outlining the key institutional actors involved in shaping securitizing dynamics at the level of the EU and the relationship between them. In so doing, the chapter seeks to clarify the relationship between actor and audience in this context and the process of identifying securitizing moves and their outcomes. The rest of the chapter is structured around three crisis events that the chapter argues have shaped securitizing dynamics evidenced at the level of the EU: the 2001 anthrax attacks in the United States; the outbreak of Severe Acute Respiratory Syndrome (SARS) in 2002-2003; and the re-emergence and spread of the H5N1 avian influenza virus in 2004-2005. Taken together, these three events marked a shift in ideational thinking at the level of the EU and played integral roles in the constitution of pandemic influenza as a particular threat subject. On the

basis of an analysis of these three events, the chapter demonstrates that it is possible to identify a process of securitization underway at EU level with political effect.

Chapter four focuses on the 2009 influenza A(H1N1) pandemic specifically and its significance for the process of securitizing pandemic influenza at the level of the EU. The 2009 influenza pandemic is analysed independent of the developments preceding it as it was the first outbreak event to test the strength of the process of securitizing pandemic influenza documented in the previous chapter. As such, it carried the potential to either validate or undermine previous securitizing claims and thus serves as an indicator of the relative success of the securitization process up to that point in time. The chapter examines both the response to the pandemic and the lessons learned from the 2009 pandemic experience as a means of assessing the impact that the 2009 outbreak event had on the securitizing process identified in the previous chapter. The chapter demonstrates that despite the ultimately relatively mild nature of the pandemic and the difficulties encountered in responding to it, the 2009 A(H1N1) influenza pandemic did not undermine the process of securitization identified to date, but rather reinforced it.

Chapter five concludes the empirical analysis with an examination of the introduction of the Commission Proposal for a Decision on serious cross-border threats to health and the discussions amongst the European Commission, the Council of the European Union, and the European Parliament that have emerged from them. The chapter demonstrates that the threat of pandemic influenza has provided a structural force for further cooperation and coordination at the level of the EU. However, the chapter also demonstrates that the process of securitization at EU level is a negotiated one. The thesis concludes with an assessment of whether pandemic influenza can in fact be considered

securitized at EU level on the basis of a summary of the findings presented throughout the body of the study, and the consequences this bears for the role of the EU as a provider of health security.

Chapter 1: Securitization theory

Introduction

This chapter introduces the theoretical framework structuring the empirical analysis that follows in the subsequent chapters. The aim of this chapter is to provide an overview of the foundations of securitization theory and the limitations inherent in the theory's empirical application, focusing particularly on the main elements of the theory relevant for the examination of the securitization of pandemic influenza at the level of the EU. The chapter argues that while securitization theory provides a theoretical means of examining the constitution of pandemic influenza as a security threat, the empirical application of the theory is unable to answer the question as to whether pandemic influenza has in fact been securitized at EU level given the current state of the art. The limitations inherent to securitization theory's empirical application relate to the domestic political context underpinning the theory and are manifested specifically in the criterion of exceptionality that marks a successful case of securitization, and in the hierarchical distinction between actor and audience.[29] The chapter argues that securitization theory needs to take seriously

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[29] A number of other scholars have made reference to the particular domestic political context underpinning the Copenhagen School's theory of securitization. Juha Vuori has commented on the implicit 'democratic bias' in the theory, while both Holger Stritzel and Paul D. Williams have questioned the applicability of securitization theory to non-democratic political settings. Vuori, J. 'Illocutionary Logic and Strands of Securitization: Applying the Theory of Securitization to the Study of Non-Democratic Political Orders', *European Journal of International Relations* 14(2008), p. 66; Stritzel, H. 'Towards a Theory of Securitization: Copenhagen and Beyond', *European Journal of International Relations* 13(2007), pp. 359-60; Williams, P.D. 'Regional Arrangements and Transnational Security Challenges: The African Union and the Limits of Securitization Theory', *African Security* 1(2008), p. 7. In a similar vein, Claire Wilkinson has argued that the Copenhagen School's theory of securitization is unsuited to empirical application in non-Western contexts on the grounds of the European understandings of society and state underpinning the theory, while Jan Ruzicka has explicated what he has identified as an established domestic political realm upon which they theory is based. Wilkinson, C. 'The Copenhagen School on Tour in Kyrgyzstan: Is Securitization Theory Useable Outside Europe?', *Security*

the institutional settings in which securitizing processes take place if it is to be able to account for processes of securitization in contexts other than the structured domestic political one upon which the theory is implicitly based.

The question of context has been taken up by a number of second-generation scholars of securitization theory, many of whom have argued for the need to engage more explicitly with the significance of audience and/or context in accounting for securitizations if the theory is to have empirical purchase.[30] Following broadly what Holger Stritzel has labelled an 'externalist' reading of securitization, these scholars place a heavier emphasis on the intersubjective establishment of security meaning rather than the performative function of the speech act itself, and are primarily concerned with accounting for the *process* of securitization.[31] In keeping with these scholars, this thesis adopts a broadly externalist approach to securitization theory as a means of providing an account of securitization amenable to empirical application at the level of the EU. This chapter thus maintains that there are two elements of securitization theory that require further clarification if the theory is to provide the tools necessary to evaluate potential securitizing processes at EU level: the role of the speech act in delineating security meaning; and the role of the audience in securitizing processes. On this note, the chapter argues that a greater emphasis needs to be placed on both context and actor-audience disposition in the generation of

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Dialogue 38(2007), pp. 5-25; Ruzicka, J. *Securitization Theory and Revolution* (Ph.D. Thesis, Aberystwyth University, Aberystwyth, 2010).

[30] See, for example, Balzacq, T. 'A theory of securitization: origins, core assumptions and variants', *Securitization Theory: How Security Problems Emerge and Dissolve*, edited by Thierry Balzacq (London & New York: Routledge, 2011), pp. 1-30; Balzacq, T. 'The Three Faces of Securitization: Political Agency, Audience and Context', *European Journal of International Relations* 11(2005), pp. 171-201; Ciută, F. 'Security and the problem of context: a hermeneutical critique of securitisation theory', *Review of International Studies* 35(2009), pp. 301-326; Stritzel, 'Towards a Theory of Securitization'.

[31] See Stritzel, 'Towards a Theory of Securitization', pp. 359-60.

security meaning if securitization theory is to carry the capacity to account for securitizing dynamics at play at the level of the EU.

The chapter proceeds by first providing an overview of the key components of securitization theory as initially articulated by the so-called Copenhagen School, discussing the normative and political underpinnings of the theory, and outlining the two broad means of empirically reading securitizations that have emerged from the Copenhagen School's initial formulation of securitization. Next, attention turns to the two elements of the theory that the chapter argues require further conceptual clarification – namely, the role of the speech act in determining security meaning and the role of the audience in the securitization process. Each will be discussed in turn. The chapter concludes with a blueprint of how securitization theory will be applied for the purposes of this thesis.

Security, the Copenhagen School and two strands of securitization thinking

Securitization theory has its intellectual roots in the early works of Ole Wæver.[32] However, the theory has been elaborated upon and detailed more systematically in the 1998 book, *Security: A New Framework for Analysis*, written by Wæver and his two colleagues, Barry Buzan and Jaap de Wilde, the three of whom are widely referred to as the 'Copenhagen School.'[33] Developed in the aftermath of the Cold War and amidst debates over the changing nature of security, securitization theory seeks to account for a widening security agenda without losing the traditional military-political meaning of the term.[34] Security, for the Copenhagen School, is thus about survival: 'It is when an issue is presented as posing an

[32] Wæver, 'Securitization and Desecuritization', pp. 46-86; Wæver, O. *Concepts of Security* (Copenhagen: University of Copenhagen, 1997).
[33] Buzan et al., *Security.*
[34] Buzan et al., *Security,* p. 4.

existential threat to a designated referent object (traditionally, but not necessarily, the state, incorporating government, territory and society).'[35]

Security, however, is not an objective condition, but is rather socially constructed and intersubjectively established. According to the Copenhagen School, in order for an issue to become a matter of security, a number of criteria need to be in play: a securitizing actor needs to first present an issue as an existential threat to a referent object. An audience then needs to accept the securitizing claim, thereby endorsing the implementation of measures that go beyond the rules that would otherwise bind. Securitization is thus a product of what Stritzel has labelled the 'trilogy' of the speech act, the securitizing actor and audience, and can be broken down into two securitizing logics: the internal coherence of the speech act itself – that is, the 'internal, linguistic-grammatical'; and the 'external, contextual and social' represented by the relationship between the securitizing actor and audience, and the character of the object claimed to be threatening.[36]

Drawing from linguistics and in particular J.L. Austin's 'speech act' theory,[37] the internal component of securitization focuses on the grammar and logic of the security utterance. In order for the internal conditions of the speech act to be met, the speech act needs to follow a particular grammar of security based on 'a plot that includes existential threat, point of no return, and a possible way out.'[38] The external conditions of the speech act, on the other hand, are dependent upon two factors: (1) the social capital of the securitizing actor; and (2) the extent to which the source of threat is generally perceived as

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[35] Buzan et al., *Security*, p. 21. See also Wæver, 'Securitization and Desecuritization', p. 53.
[36] Stritzel, 'Towards a Theory of Securitization', p. 358; Buzan et al., *Security*, p. 32.
[37] See Austin, J.L. *How To Do Things With Words* (Oxford: Oxford University Press, 1962).
[38] Buzan et al., *Security*, p. 33.

being threatening.[39] The triangulation of these three components – the internal demand that the speech act follow the grammar of security, the relationship between the authoritative speaker and the accepting audience, and the recognised threatening features of the threat subject – provide what the Copenhagen School has identified as the facilitating conditions necessary for securitization to succeed.[40]

As Felix Ciută has pointed out, at the heart of the Copenhagen School's theory of securitization are thus two definitions of security: a 'discursive' definition that locates security meaning in the speech act articulation, and a second definition, located in the logic of the speech act itself and based on a traditional understanding of security as survival in the face of existential threat.[41] It is through the combination of these two meanings that the Copenhagen School has sought to provide an account of security that 'sticks to the traditional core of the concept of security (existential threats, survival), but is undogmatic as to both sectors (not only military) and referent objects (not only the state).'[42] Ciută has argued that these two definitions of security are not only 'radically distinct', but are also hierarchically situated whereby the traditional definition of security is favoured over the discursive definition with the effect that the meaning of security is locked and unamenable to 'conceptual variation or practical reformulation.'[43] While the issue of locating security meaning will be discussed in more detail in the next section of this chapter, what is important to note here is that it is neither *security* nor the *logic of security* that are socially constructed in the Copenhagen School's account of securitization, but rather *threats*

[39] Buzan et al., *Security*, p. 37.
[40] Buzan et al., *Security*, pp. 32-3.
[41] Ciută, 'Security and the problem of context', p. 306.
[42] Wæver, O. 'European Security Identities', *Journal of Common Market Studies* 34 (1996), p. 110, quoted in Ciuta, 'Security and the problem of context', p. 306.
[43] Ciută, 'Security and the problem of context', p. 307.

through the framing of particular issues as existential threats.[44] The focus of analysis for the Copenhagen School, then, is not on what security *is*, the definition of security already established, but rather on what a security articulation *does* – that is, the performative capacity of a security utterance to move an issue into the realm of exceptionality.[45] It is this focus on the discursive constitution of threat that enables pandemic influenza to be recognised and analysed as a threat subject.

The location of security meaning in the notions of existential threat, survival and exceptionality brings to the fore the normative dimension of the Copenhagen School's project and points to what Michael C. Williams has suggested is an influence drawn from Carl Schmitt in the Copenhagen School's theoretical framework. Williams maintains that the Copenhagen School's designation of security as 'a particular *kind* of speech act [emphasis original]' is informed by Schmitt's concept of 'the political.'[46] The Schmittian definition of politics as exclusion and enmity thus parallels the Copenhagen School's focus on 'existential threats' as a defining feature of security, just as the role of the sovereign in designating threatening 'others' and enabling the 'exception' in Schmitt's theory parallels the Copenhagen School's emphasis on exceptionality and the move 'beyond normal politics' as the defining feature of securitization.[47] As Matt McDonald has pointed out, for the Copenhagen School, this logic of security is central to their call for desecuritization and it is here where the normative dimension of the Copenhagen School's theory of securitization comes to the fore.[48] Security, for the Copenhagen School, is not assumed to be a positive

[44] Ciută, 'Security and the problem of context', p. 308.
[45] Stritzel, 'Towards a Theory of Securitization', p. 361.
[46] Williams, M. C. 'Words, Images, Enemies: Securitization and International Politics', *International Studies Quarterly* 47(2003), p. 515.
[47] Williams, 'Words, Images, Enemies', p. 515; McDonald, M. 'Securitization and the Construction of Security', *European Journal of International Relations* 14(2008), p. 578.
[48] McDonald, 'Securitization and the Construction of Security', p. 578.

value, but rather is indicative of 'a failure to deal with issues as normal politics.'[49] Whereas politicization entails promoting an issue in a manner that is open and that is based on responsibility and choice, securitization takes an issue beyond the rules of normal politics on the basis of its presentation as both urgent and existential.[50] The optimal condition to be strived for is therefore desecuritization – that is, 'the shifting of issues out of emergency mode and into the normal bargaining process of the daily political sphere.'[51]

Important for the purposes of this thesis, underpinning this normative preference for desecuritization and the logic of security informing it is a presumed political context where deliberation on political issues is the political norm and where the competence of the sovereign allows political leaders to declare the exception. In fact, for both Juha Vuori and McDonald, the emphasis placed on desecuritization and exceptionality points to a democratic political setting inherent to the Copenhagen School's theory of securitization. This is indicated by the tripartite distinction between non-political, political and security issues, non-political issues being outside the purview of the state, political issues within the realm of 'normal politics' which McDonald asserts 'seems to rely on institutions and dynamics of Western liberal democracies', and security issues relegated to the area of 'special politics' marked by 'non-democratic decision-making due to necessities of survival.'[52] McDonald maintains that the Copenhagen School's normative preference for desecuritization implies 'a commitment to deliberation and democratic political process' on two fronts:

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[49] Buzan et al., *Security*, p. 29.
[50] Buzan et al., *Security*, p. 29.
[51] Buzan et al., *Security*, p. 4.
[52] McDonald, 'Securitization and the Construction of Security', p. 581; Vuori, 'Illocutionary Logic and Strands of Securitization', p. 69. See also McDonald, M. 'Deliberation and Resecuritization: Australia, Asylum-Seekers and the Normative Limits of the Copenhagen School', *Australian Journal of Political Science* 46(2011), p. 283.

> First, security is seen as belonging to the realm of emergency entailing a negative and exclusionary logic in which the process of decision making is 'anti-democratic' in form….Second, and following from this, exposing issues to the 'normal' political process of deliberation, negotiation and contestation (desecuritization) is seen as preferable to allowing those issues to be addressed 'above' politics…[53]

Elaborating upon the points raised by Vuori and McDonald, Jan Ruzicka has identified five aspects of the Copenhagen School's theory of securitization that suggests what he identifies as an assumed established political realm underpinning the theory: (1) the emphasis placed on exceptionality through the breaking free of rules that would otherwise apply; (2) the three stages through which an issue has to go in order to become a security issue (from depoliticized, to politicized to securitized); (3) the normative preference for desecuritization; (4) the emphasis placed on the political choice to securitize or accept a securitization; and (5) the implication that means are available to counter an existential threat.[54] Yet, despite the particularly structured political context assumed by securitization theory, the Copenhagen School does suggest that the theory is applicable outside a particular domestic political setting. This is evidenced by the linking of securitization theory to regional security complexes as well as by the introduction of the concept of macrosecuritization by both Buzan and Wæver.[55] Both of these concepts elaborate upon the possibility of multiple securitizations taking place at different levels of analysis. The difficulty in applying the Copenhagen School's securitization theory to different empirical settings, then, lies not in a presumed misappropriation of the theory, but rather, this chapter argues, in a tension

[53] McDonald, 'Deliberation and Resecuritization', p. 283.
[54] Ruzicka, *Securitization Theory and Revolution*, p. 24.
[55] Buzan, B. & O. Wæver. 'Macrosecuritisation and security constellations: reconsidering scale in securitisation theory', *Review of International Studies* 35(2009), pp. 253-276; Buzan, B. & O. Wæver. *Regions and Powers: The Structure of International Security* (Cambridge, Cambridge University Press, 2003).

inherent to the theory itself between the performative force of the security utterance and the external context in which the speech act takes place.

In fact, while the Copenhagen School's formulation of securitization seeks to unproblematically reconcile the internal logic of the speech act with its external conditions, both Stritzel and Thierry Balzacq have asserted that the Copenhagen School's framework encompasses two distinct means of reading securitization. For Stritzel, the Copenhagen School appears to conflate the securitization *process* with the speech act/utterance to the effect that the speech act is simultaneously defined as an intersubjective process of threat construction and as an utterance in and of itself. Yet, Stritzel argues, 'the (decisionist) performativity of security utterances as opposed to the social process of securitization, involving (pre-existing) actors, audience(s) (and contexts), are so different that they form two rather autonomous centres of gravity.' [56] Stritzel has labelled these two centres of gravity 'internalist' and 'externalist'. While the internalist centre draws from poststructuralism/postmodernism and is focused on the performative act of speaking security, the externalist centre is constructivist in orientation and concerned with accounting for the *process* of securitization.[57]

In a similar vein, Balzacq has identified two strains of securitization theory that have developed out of the Copenhagen School's initial formulation: a 'philosophical' strain, rooted in poststructuralism and focused on the power of language and the speech act in constituting threat, and a 'sociological' strain that emphasizes the significance of practices, context and power relations in facilitating securitization.[58] As with Stritzel, Balzacq

[56] Stritzel, 'Towards a Theory of Securitization', p. 364.
[57] Stritzel, 'Towards a Theory of Securitization', pp. 359-60.
[58] Balzacq, 'A theory of securitization', p. 1.

maintains that the Copenhagen School suggests that security is simultaneously a self-referential practice and an intersubjective process. Ultimately, however, Balzacq argues that the Copenhagen School leans towards the former reading to the detriment of the latter.[59] Both Stritzel and Balzacq, then, have advocated for an externalist/sociological reading of securitization theory as a means of adequately capturing securitizing dynamics in different empirical settings. For Balzacq in particular, this entails taking the speech act beyond its normative, essentialist framing and resituating it in a social sphere, described by Balzacq as 'a field of power struggles in which securitizing actors align on a security issue to swing the audience's support toward a policy or course of action.'[60]

In keeping with both Stritzel and Balzacq, this chapter argues that an externalist/sociological reading of securitization theory is necessary if the theory is to take seriously the institutional and political settings in which processes of securitization take place. In so doing, the normative dimension of the Copenhagen School's theory of securitization is set aside in favour of an approach that follows Balzacq in recognising securitization as a 'strategic (pragmatic) practice.'[61] Such an approach focuses on the use of persuasion in bringing about the goals of a securitizing actor rather than the universal principles of a speech act articulation and thereby necessarily brings to the fore the relational role and position of audience in the securitization process as well as the interplay between the speech act and external context in generating security meaning.[62] The next two sections of this chapter will outline this approach in more detail, first by examining the role of the speech act in delineating security and then by focusing on the role of the

[59] Balzacq, 'The Three Faces of Securitization', p. 179.
[60] Balzacq, 'The Three Faces of Securitization', p. 173.
[61] Balzacq, 'The Three Faces of Securitization', p. 172.
[62] See Balzacq, 'The Three Faces of Securitization', p. 172.

audience in the securitization process. It is to the speech act and the location of security meaning that attention now turns.

The speech act and locating security meaning

For the Copenhagen School, the constitutive role of language in delineating threat is important in that it designates the identification of 'threat' to a product of social design and thereby a normative political act.[63] A particular issue is placed in the field of exceptionality on the basis of the performative act of security articulation, enabling the issue to be responded to as a security concern irrespective of whether the issue can be considered an objective threat. The performative act of speaking security thus takes the identification of a security threat outside of the conventional dichotomy of true and false to focus on what happens because of a particular security utterance.[64] As Wæver has asserted, it is by focusing on the performative articulation of security that securitization theory is able to bring to the fore 'the inherently political nature of any designation of security issues', enabling in turn the questioning of why a particular public concern is labelled a security issue and what implications the labelling or not labelling of a phenomenon as a security issue carries for how that phenomenon is subsequently addressed.[65]

The discursive constitution of threat in the Copenhagen School's account of securitization theory, however, has been criticized by a number of second-generation scholars of securitization on three grounds: First, it offers a static account of security; second, it downplays the significance of contextual factors in generating security meaning;

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[63] Balzacq, T. 'Preface', in *Securitization Theory: How Security Problems Emerge and Dissolve*, edited by Thierry Balzacq (London & New York: Routledge, 2011), p. xiii.
[64] Stritzel, 'Towards a Theory of Securitization', p. 361.
[65] Wæver, O. 'Securitizing Sectors? Reply to Erikkson', *Cooperation and Conflict* 34(1999), p. 334.

and third, it fails to account for alternative forms of conveying security meaning, such as through the use of visual images or the media, through symbolic and bodily forms of communication, through bureaucratic practices and even 'apparently mundane and everyday physical actions.'[66]

With respect to the first point, the fixed meaning of security as exceptionality, encapsulated in the moment and logic of the speech act, proves empirically problematic for the purposes of this thesis on two interrelated fronts: First, it locates security meaning in a specific utterance at a particular moment in time and second, in so doing, upholds a dichotomy between politicization and securitization. The presumption is not only that the move from politicization to securitization can be pinpointed to a particular moment, but also that securitization takes place within a context where exceptional measures are possible. Indeed, for Stritzel, the location of security meaning in the moment and logic of the speech act limits the capacity of securitization theory to be applied to the empirical world:

[66] McDonald, 'Securitization and the Construction of Security', p. 569. For a discussion on the static account of security and the importance of contextuality in locating security meaning, see Ciută, 'Security and the problem of context' or Stritzel's work on security as translation: Stritzel, H. 'Securitization, power, intertextuality: Discourse theory and the translations of organized crime', *Security Dialogue* 43(2012), pp. 549-567; Stritzel, H. 'Security as translation: threats, discourse, and the politics of localisation', *Review of International Studies* 37(2011), pp. 2491-2517; Stritzel, H. 'Security, the translation', *Security Dialogue* 42(2011), pp. 343-355; Stritzel, 'Towards a Theory of Securitization'. For analyses focused on the limitations of the speech act in conveying security meaning and the significance of non-verbal forms of communication for securitization, see Balzacq, T. 'The Policy Tools of Securitization: Information Exchange, EU Foreign and Interior Policies', *Journal of Common Market Studies* 46(2008), pp. 75-100; Hansen, L. 'The Little Mermaid's Silent Security Dilemma and the Absence of Gender in the Copenhagen School', *Millennium* 29(2000), pp. 285-306; Hansen, L. 'Theorizing the image for Security Studies: Visual securitization and the Muhammad Cartoon Crisis', *European Journal of International Relations* 17(2011), pp. 51-74; Möller, F. 'Photographic Interventions in Post-9/11 Security Policy', *Security Dialogue* 38(2007), pp. 179-196; Vuori, J. 'A Timely Prophet? The Doomsday Clock as a Visualization of Securitization Moves with a Global Referent Object', *Security Dialogue* 41(2010), pp. 255-277; Williams, 'Words, Images, Enemies', pp. 525-7.

> In reality, the speech act itself, i.e. literally a *single* security articulation at a *particular* point in time, will at best only very rarely explain the entire social process that follows from it. In most cases a security scholar will rather be confronted with a *process* of articulations creating sequentially a threat text which turns sequentially into a securitization [emphases original].[67]

On this point, Stritzel has argued that many security issues post-Cold War have in fact been addressed *below* the level of exceptionality, arguing therefore for an approach to securitization theory that places less weight on the formal requirements of the securitizing move.[68] In a similar vein, scholars such as Didier Bigo and Sarah Léonard have argued that issues can be gradually institutionalized as security threats absent any dramatic intervening moment, while Rita Abrahamsen has noted that the Copenhagen School's account of securitization fails to recognise that security practices can operate on a continuum, ranging from worrisome or troublesome to risk and to threat and back to normalcy again.[69]

The inability of the Copenhagen School's analytical framework to capture securitizing processes absent a distinct moment of intervention marked by exceptionality becomes particularly apparent when attempting to apply securitization theory to the level of the EU. In the case of the EU, the sovereign capacity to declare the exception does not exist, nor does a clear hierarchical distinction between actor and audience. Indeed, not only is the criterion of exceptionality ill-suited to the EU context, but so also is the concomitant assumption of a static and identifiable 'normal' that can be transcended through securitization. The characteristically 'technocratic nature of political, legal and institutional

[67] Stritzel, 'Towards a Theory of Securitization', p. 377.
[68] Stritzel, 'Security as translation', p. 2493.
[69] Bigo, D. 'Security and Immigration: Toward a Critique of the Governmentality of Unease', *Alternatives: Global, Local,* Political 27(2002), p. 73; Léonard, S. *The European Union and the 'Securitization' of Asylum and Migration: Beyond the Copenhagen School's Framework* (Ph.D. Thesis, University of Wales, Aberystwyth, Aberystwyth, 2007), pp. 75-6; Abrahamsen, R. 'Blair's Africa: The Politics of Securitization and Fear', *Alternatives* 30(2005), p. 59.

processes' at EU level suggests that securitizations in this setting are unlikely to function as a binary, nor are they likely to be pinpointed to a specific utterance at a particular moment in time.[70] Moreover, the continued evolution of the EU from an economic entity to an increasingly political one, and the consequent accretion of new functions and competences that have accompanied this process, demonstrates that what is considered 'normal' in this context has altered significantly over time. The EU, then, constitutes a setting that does not conform to the particularly structured political context underpinning the Copenhagen School's theory of securitization. What this suggests is that security meaning in this context cannot be relegated to the moment and logic of the speech act itself. Rather, in keeping with an externalist reading of securitization theory, this chapter argues that greater attention needs to be paid to the significance of context and actor-audience disposition in the generation of security meaning if the significance of setting is to be taken seriously in securitization theory.

In an effort to move beyond the centrality of the speech act in generating security meaning, a number of scholars of securitization theory have argued for a greater focus on the role of context in determining the meaning of security, while others have argued for the need to recognise texts, including 'the symbolic language of visuals/images and sound' and practices as important sites of securitization in and of themselves.[71] Balzacq, for example, has argued that security meaning needs to be recognised as located at the intersection between language and context: 'The semantic repertoire of security is a combination of

[70]Neal, A. 'Securitization and Risk at the EU Border: The Origins of FRONTEX', *Journal of Common Market* Studies, 47(2009), p. 337. On this point, Neal has argued that policy outcomes are unlikely to resemble securitizations as defined by the Copenhagen School, while Sarah Léonard has argued that securitizations at the level of the EU are somewhat counter-intuitive given the characteristically technocratic nature of the body. Neal, 'Securitization and Risk at the EU Border, p. 337; Léonard, S. *The European Union and the 'Securitization' of Asylum and Migration*, p. 9.
[71] Stritzel, 'Towards a theory of securitization', p. 370. See footnote 66 for a list of relevant articles.

textual meaning – knowledge of a concept acquired through language (written and spoken) – and cultural meaning – knowledge historically gained through previous interactions and situations. Taken together, these two kinds of meanings form a frame of reference through which security utterances can be understood.'[72] Rather than placing analytical emphasis on the universal principles of the speech act, Balzacq has argued that securitization should be understood as a 'strategic (pragmatic) practice' whereby the focus of analysis is on the use of *persuasion* in bringing about the goals of the securitizing actor.[73] Such an approach moves securitization theory beyond the Copenhagen School's normative agenda by situating the speech act 'in the social context, a field of power struggles in which securitizing actors align on a security issue to swing the audience's support toward a policy or course of action.'[74] In so doing, Balzacq brings to the fore the role of external contextual developments and the situated role of the audience in determining the success of a securitization.

For Colin McInnes and Simon Rushton, the significance of reframing the speech act as a form of argumentative process as proposed by Balzacq is that it 'opens the door for empirical "evidence" in support of the securitizing claims to play a much more significant role than internalist versions of securitization theory would admit.'[75] On this point, Balzacq maintains that there is an important distinction to be made between what he labels 'institutional' and 'brute' threats when analysing processes of securitization. Whereas institutional threats are those threats established through language mediation, brute threats are those that constitute actual hazards for human life.[76] While for the Copenhagen School, an objective consideration of threat introduces an incompatible ontology in that it

[72] Balzacq, 'The Three Faces of Securitization', p. 183.
[73] Balzacq, 'The Three Faces of Securitization', p. 172.
[74] Balzacq, 'The Three Faces of Securitization', p. 173.
[75] McInnes & Rushton, 'HIV/AIDS and securitization theory', p. 6.
[76] Balzacq, 'The Three Faces of Securitization', p. 181.

‘ultimately undermines the basic idea of security as a specific social category that arises out of, and is constituted in, political practice,’[77] for Balzacq, if the speech act is to be understood as an act of persuasion, then the articulation of threat needs to resonate with an external context whereby an audience is receptive to its vulnerability.[78]

McInnes and Rushton take Balzacq’s argument one step further by arguing that not only may external events impact the success of a securitizing move, but also, when doubts arise as to the empirical validity of a securitization, the arguments supporting that securitization may be undermined, spurring in turn a process of desecuritization.[79] As McInnes and Rushton have articulated, the point that all three scholars make is not that an empirical ‘truth’ exists independent of the speech act, but rather that the speech act shapes how events in the empirical world are understood. In so doing, however, the speech act is itself subject to empirical verification and the success of a securitization, as well as its duration, will thus depend on the extent to which a claim to security resonates with its immediate context.[80] The significance of external events for the securitization process would seem particularly relevant for the study of the securitization of pandemic influenza. As an event that is cyclical in nature, the success of a securitizing move arguably rests with the perceived criticality of the moment in which the security articulation is uttered. For Balzacq, as well as for McInnes and Rushton, then, security meaning is not located in the speech act itself, but rather is co-constituted by language and context, audience playing a central role in determining the success of a securitization attempt.

[77] Buzan et al., *Security*, p. 40.
[78] Balzacq, ‘A theory of securitization’, p. 13.
[79] McInnes & Rushton, ‘HIV/AIDS and securitization theory’, p. 4.
[80] McInnes & Rushton, ‘HIV/AIDS and securitization theory’, p. 4; Balzacq, ‘The Three Faces of Securitization’, p. 182; Balzacq, ‘A theory of securitization’, p. 13.

Whereas Balzacq draws attention to the role of external contextual developments in lending support to securitizing claims and the contextually situated role of audience in determining the success of a securitization, scholars such as Felix Ciută and Holger Stritzel have argued for an approach to securitization theory that focuses on the contextually situated production of security meaning in and of itself. On this point, Ciută has argued that security meaning is contextually determined and located in the negotiated space between theory and practice. According to Ciută, the construction of security needs 'to be understood as a practice (whose result is the meaning of security) that contextually constitutes other practices (thereby known as security policies), which contribute themselves to the continuous construction, sedimentation, and re-negotiation of what security means.'[81] Rather than the analyst identifying security situations as defined by the logic of the speech act, Ciută maintains that emphasis should be placed on the identification of security situations as evoked by actors themselves, such as when actors use the term 'security' without necessarily following the logic of existential threat, point of no return and possible way out.[82]

Thus, while the Copenhagen School argues that it is not the use of the term 'security' that necessarily signals a securitizing move, but rather the deployment of the logic of existential threat, Ciută argues that by dissociating the word 'security' from the practice of securitization, the Copenhagen School provides definitional stability at the expense of being able to account for changes in security meaning as demonstrated empirically.[83] Stritzel has made a related argument, asserting that the static account of security offered by the Copenhagen School is ahistorical not only because it 'overlooks the genealogy and historical

[81] Ciută, 'Security and the problem of context', p. 309.
[82] Ciută, 'Security and the problem of context', p. 310.
[83] Ciută, 'Security and the problem of context', pp. 309-310. See also Buzan et al., *Security*, p. 33.

contingency of the concept of security', but also because it '"closes" the meaning of security by fixing it as a "politics of exception".'[84] In a similar vein, focusing on the convergence of the realms of health and security in particular, Stefan Elbe has argued that securitization theory is unable to account for how the practice of security has altered with the introduction of such non-military challenges as infectious diseases to the field of security.[85] On this point, Elbe has argued that the rise of the notion of health security has shifted the way in which security is practiced on three points: (1) by reconfiguring how security is defined; (2) by introducing new actors to the field of security; and (3) by changing how security is provided.[86] The static account of security offered by the Copenhagen School is not only unable to accommodate these changes, but is also somewhat ironic given that Buzan and Wæver have asserted that 'security is what actors make of it.'[87]

For Ciută, then, to study security is necessarily to study '*particular definitions* [emphasis original] of security, which constitute not only the practices that define threats, but also those through which security is achieved, for example measures whose exceptionality is context-bound.'[88] Measures implemented in response to a securitizing argument – whether considered 'exceptional' in the Copenhagen School sense or not – are thus defined as *security* measures on the basis of the contextual definitions of security with which they correspond.[89] The focus of analysis thus falls not only on how actors define security through the use of the term in practice, but also on the constitutive force of these practices in shaping how the meaning of security evolves. On this point, Ciută has argued

[84] Stritzel, 'Security, the translation', p. 347.
[85] Elbe, S. *Security and Global Health: Toward the Medicalization of Insecurity* (Cambridge & Malden, Polity, 2010), p. 15.
[86] Elbe, S. 'Pandemics on the Radar Screen: Health Security, Infectious Disease and the Medicalisation of Insecurity', *Political Studies* 59(2011), p. 849; Elbe, *Security and Global Health*, pp. 23-8.
[87] Buzan & Wæver, *Regions and Powers,* p. 48.
[88] Ciută, 'Security and the problem of context', p. 314.
[89] Ciută, 'Security and the problem of context', p. 314.

not for the 'boundless meaning of security', but rather has sought to account for its 'boundedness' while also recognising that 'sedimented categories of meaning can change.'[90] This differs from Stritzel's work, which eschews the role of actor and audience in the securitization process in favour of a focus on what he calls 'acts of translation' by which particular threat texts enter into existing discourse. Stritzel thus goes one step further than Ciută in arguing that security meaning(s) can only be contextually situated and cannot be studied at any wider level of abstraction.[91]

Taken together, Balzacq and Ciută provide a means of accounting for securitizations at EU level absent any distinctive securitizing event. By reconfiguring securitization as a 'strategic (pragmatic) practice', Balzacq enables the reorientation of securitization theory away from a preoccupation with the dichotomy between politicization and securitization, and the specific political context underpinning the distinction, to focus on the strategic use of language as a means of achieving a particular end. Securitization is thus defined by Balzacq as the mobilization of heuristic artefacts by a securitizing actor as a means of conveying to an audience the critical vulnerability of a referent object and the threatening qualities of the referent subject, in order to enable the immediate implementation of a customized policy to block the referent subject's development.[92] Contra Stritzel, actor and audience play a central role in the securitization process. Moreover, semantic regularity is held in the logic of extreme or existential threat and priority for action.

Exceptionality in the context of the EU, however, is necessarily context-bound and it is here where Ciută's analysis comes into play. Not only are securitizations at EU level likely

[90] Ciută, 'Security and the problem of context', p. 321.
[91] Stritzel, 'Towards a Theory of Securitization', p. 371. See also: Stritzel, 'Securitization, power, intertextuality'; Stritzel, 'Security as translation'; Stritzel, 'Security, the translation'.
[92] Balzacq, 'A theory of securitization', p. 3.

to take the form of a process rather than an event, making exceptionality difficult to locate, but securitizing moves have to function within the parameters of what is constitutionally allowed. On this point and drawing from Ciută, this chapter argues that exceptionality can be determined in relation to the securitizing arguments and practices that precede a particular course of action. These practices themselves hold constitutive force in that they provide a new basis for security iterations and practices that follow. In the case of the EU, exceptionality can be determined in relation to the expansion of the EU's activities and competences in providing for health security, as facilitated by the securitizing discourses and practices that precede these developments.

It is worth noting here those scholars, including Balzacq, who have proposed redirecting analyses away from the discursive articulation of security in favour of a focus on non-discursive means of conveying security meaning. Focusing on the EU in particular, both Balzacq and Léonard have asserted that an analysis of what Balzacq has labelled policy tools or instruments of securitization provides an alternative means of reading securitizations at EU level, particularly given the Union's unique political and institutional features. For Léonard, the focus on practices is particularly useful in the study of the perpetuation of securitizations at the level of the EU for two reasons: First, in the case of an institutionalized security issue, an analysis of the practices of institutions established to address the particular issue can reveal the existence of securitizing dynamics that a focus on discourse may overlook; and second, the unlikely presence of 'dramatic securitizing speech acts'

identifiable in national contexts due to the unique features of the EU suggest, according to Léonard, that a focus on practices may be more suitable in this context.[93]

For his part, Balzacq maintains that the utility of focusing on policy tools or instruments of securitization when analysing securitizing dynamics in the EU arises from what he identifies as the increasing entanglement of discourse and ideology and the blurred distinction between actor and audience.[94] Balzacq thus asserts that a focus on policy tools or instruments of securitization can provide a means of not only accounting for transformations in securitizations in both scope and scale, but also 'variations of intensity *within* [emphasis original] the process of securitization' over time, thereby providing a more complete picture of the constitution of threats at any given moment than a discursive approach to security can offer.[95] Defined by Léonard as 'activities that, by their very intrinsic qualities, convey the idea to those who observe them, directly or indirectly, that the issue they are tackling is a security threat,' tools or practices of securitization are thus considered to provide a means of accounting for both the evolution of security meaning over time and the possibility of security dynamics at play below the level of exceptionality.[96]

This chapter argues, however, that while practices can carry constitutive force, these practices cannot be analysed independent of discourse. In fact, while Balzacq and Léonard do not explicitly engage with discourse in their respective analyses of securitizing tools or

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[93] Léonard, S. 'EU border security and migration into the European Union: FRONTEX and securitisation through practice', *European* Security 19(2010), p. 236.
[94] Balzacq, 'The policy tools of securitization', p. 76.
[95] Balzacq, 'The policy tools of securitization', pp. 76, 78.
[96] Léonard, 'EU border security and migration into the European Union', pp. 237-8; Balzacq, 'The policy tools of securitization', p. 237. In a similar vein, scholars focusing on the 'visual turn' in securitization studies maintain that images themselves are important sites for examining securitizing/desecuritizing processes, Lene Hansen arguing that visual images should not be considered subordinate to discourse but rather recognised as carrying their own potential for making security utterances by being intertextually constituted to speak security. Hansen, 'Theorising the image for security studies', p. 54. See also Williams, 'Words, Images, Enemies', p. 527. For other articles focusing on visual securitizations, see footnote 66.

practices, underpinning their arguments is an assumption that a securitizing move has already taken place. Furthermore, while both Balzacq and Léonard identify attributes meant to distinguish security tools or instruments from regular policy practices, what remains less convincing is how these attributes inherently signal security absent a discursive indicator that this should be the case.[97] While policy tools and instruments can certainly inform processes of securitization, this chapter argues that the indeterminate status of these tools or instruments limits their analytical use absent any analysis of the discursive arguments that constitute and are constituted by them.

This is certainly the case when analysing the securitization of pandemic influenza at the level of the EU for two reasons: First, the EU's policy practices have changed considerably over time and not necessarily for reasons of security; second, as has already been suggested, how security itself is practiced is also subject to change. An analysis of practice independent of discourse does not provide a means of distinguishing between what can be considered 'regular' policy practices and security practices, particularly in a field that is in the process of emerging. Thus, rather than being tangential to the process of securitization, this chapter argues that discourse remains central to it. The central focus of this thesis, then, is on what Balzacq has called the 'discursive politics of security.'[98] The strategic use of language remains at the centre of analysis, as does the role of audience in determining the success of a securitization. On this point, the chapter argues that while the distinction between actor and audience may not always be clear at EU level, securitizing

[97] The same can be said for the work on visual securitizations. While visual images carry the capacity to convey meaning, given the inherent ambiguity of this meaning, it is unclear as to precisely how an image can securitize absent any discursive mediation. Hansen herself acknowledges this point, stating that while images can 'lend themselves to specific political interpretations or open up spheres for action', they cannot create policy: 'Linguistic security therefore will almost always specify what policies should be undertaken to address the threat identified.' Hansen, 'Theorizing the image for security studies', p. 58.

[98] Balzacq, 'The Three Faces of Securitization', p. 172.

dynamics can still be accounted for on the basis of the interaction between discourse and practice over time as the introduction of the latter in response to the former would indicate a collective willingness to act on a securitizing claim.

To sum up, then, this section has argued for an approach to securitization theory whereby the securitizing move is recognised as a strategic act of persuasion geared to convince an audience to take a particular course of action based on an argument of extreme or existential threat and a priority for action. Context plays a role in the constitution of security meaning both as it concerns the role of external events and the contextually situated role of audience in determining the success of a securitization, and as it concerns the parameters set on the securitization process by the institutional setting itself. Exceptionality is thus context-bound and in the case of the EU, can be determined by analysing both the discursive articulations of threat and the practices put in place to address it. These practices themselves have constitutive force in that they set the basis for subsequent security articulations and actions. Securitization can thus be analysed as a process, demarcated by specific clusters of securitizing discourses and practices that signal the various stages of this process over time. Audience, however, remains central to securitization and the next section of this chapter will outline the role of audience in more detail.

Actor-audience disposition and the role of audience in the securitization process

The significance of the relationship between actor and audience for the Copenhagen School rests with the notion that security is intersubjectively established. Threat assessment, in this

sense, is split between actor and audience in that the audience has to accept the actor's securitizing move in order for securitization to be successful.[99] The role of audience, however, is undertheorized in the Copenhagen School's original account of securitization and has been criticized for being ambiguous both in relation to its role and composition.[100]

The Copenhagen School is careful to state that audience acceptance of a securitizing move does not have to result in the adoption of emergency measures, 'only that the existential threat has to be argued and just gain enough resonance for a platform to be made from which it is possible to legitimize emergency measures or other steps that would not have been possible had the discourse not taken the form of existential threats, point of no return, and necessity.'[101] However, as both Stritzel and Mark Salter have pointed out, not only is it difficult to identify relevant audience(s) in the Copenhagen School's theory of securitization, but also to determine at what point an audience is 'persuaded.'[102]

What the precise role of the audience is in accepting or rejecting a securitizing move and how audience is conceptualized differs amongst scholars depending on how Austin's speech act theory is read. According to Balzacq, the total situation of Austin's speech act is made up of three components: the locutionary component, referring to the articulation itself; the illocutionary act, referring to the act performed by the articulation; and the perlocutionary situation, referring to the effects brought about by the performed

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[99] Stritzel, 'Towards a Theory of Securitization', p. 363.
[100] See, for example, Balzacq, 'A theory of securitization', p. 20; Balzacq, 'The Three Faces of Securitization', pp. 177-8; Léonard, S. & C. Kaunert. 'Reconceptualizing the audience in securitization theory', in *Securitization Theory: How Security Problems Emerge and Dissolve*, edited by Thierry Balzacq (London & New York, Routledge, 2011), pp. 60-1; McDonald, 'Securitization and the Construction of Security', p. 573; Roe, P. 'Actor, Audience(s) and Emergency Measures: Securitization and the UK's Decision to Invade Iraq', *Security Dialogue* 39(2008), pp. 615-635; Salter, M. B. 'Securitization and desecuritization: a dramaturgical analysis of the Canadian Air Transport Security Authority', *Journal of International Relations and Development* 11(2008), pp. 321-349; Stritzel, 'Towards a Theory of Securitization', p. 363.
[101] Buzan et al., *Security*, p. 25.
[102] Salter, 'Securitization and desecuritization', p. 324; Stritzel, 'Towards a Theory of Securitization', p. 363.

articulation.[103] The role attributed to audience in the securitizing process depends on whether emphasis is placed on the directional effect of the illocutionary act in producing audience, thereby locating perlocutionary effect within the speech act itself, or whether one interprets perlocution as existing outside the speech act and representing the negotiated process by which an already constituted audience endorses or rejects the securitizing actor's claims. While the former approach does not require the explicit identification of audience, as it is the speech act itself that produces audience, the latter approach places emphasis on the prior constitution of audience and the context in which it is situated. Stritzel has outlined the difference in the two approaches as follows:

> Generally speaking, the more emphasis is put on the notion of 'illocution', the less important the concept of 'audience' seems to become, as the modus of security could be thought of as being constituted by the illocutionary utterance *itself.* Conversely, the more emphasis is put on the notion of 'audience', the more strongly securitization seems to move towards 'perlocution' and the study of how exactly speakers (through various linguistic tropes, symbols and other discursive resources) *persuade* audiences [emphases original].[104]

While both approaches may still attribute a central role to audience in the securitization process, how that audience is identified and how its role is conceptualized will depend on the approach to the speech act taken.

For Balzacq, for example, focusing on perlocutionary effect is essential in understanding how a given issue can be transformed into a security problem, particularly if security is recognised as being intersubjectively established and contingent upon an

[103] Balzacq, 'The Three Faces of Securitization', p. 175.
[104] Stritzel, 'Security, the translation', p. 349.

audience's acceptance of the securitizing move. In fact, it is precisely the lack of attention given to the constitution of audience in securitization theory by the Copenhagen School that has led Balzacq to claim that the Copenhagen School's framework ultimately ignores that audience, favouring security as an illocutionary act or a 'self-referential' practice rather than also incorporating the significance of perlocution to the model.[105] For Balzacq, perlocution should not be understood as belonging literally to the speech act itself, but rather as constituting the causal response to the linguistic act and particular to the situation in which the speech act is uttered. Thus, while illocution is conventionally achieved by satisfying all four 'felicity conditions' of the speech act, perlocution is caused by a combination of text and context that make up a particular utterance and thus includes both the intended and unintended effects that this combination may cause.[106]

The consequence of favouring an illocutionary reading of security, according to Balzacq, is that the Copenhagen School's theory of securitization does not provide a means of determining the proportionate weight that should be attributed to audience and context in the securitization process.[107] If securitization is to be understood as a strategic (pragmatic) act, or an exercise in persuasion rather than a conventional procedure, then the co-constitution of the securitizing move through the actor-audience relationship is fundamental to the generation of security meaning and audience must necessarily exist prior to the speech act articulation. Audience, then, is understood by Balzacq as an 'empowered' one, defined as an audience with a direct causal connection to the issue at hand and with the ability to grant the securitizing actor the mandate to take the perceived

[105] Balzacq, 'A theory of securitization', p. 20; Balzacq, 'The Three Faces of Securitization', pp. 177-8.
[106] Balzacq, 'A theory of securitization', p. 5.
[107] Balzacq, 'A theory of securitization', p. 20; Balzacq, 'The Three Faces of Securitization', p. 178.

necessary measures to address the identified threat.[108] In endorsing a securitizing move, moreover, the empowered audience may also be agreeing to take the recognised necessary measures themselves.

Contra Balzacq, Vuori has argued that an illocutionary reading of the speech act is necessary if securitization theory is to be amenable to different empirical settings while retaining the capacity for case comparison. This is so precisely because the illocutionary act functions on the basis of underlying rules or conventions of language. On this point, Vuori has argued that securitizations can take various strands depending on the intention of the speech act – that is, whether the aim is to raise an issue on the agenda, legitimate a particular course of action (future or past), deter, or control.[109] Each strand can have various and parallel audiences depending on the function the securitization act is intended to serve.[110] A particular illocutionary act will therefore have different perlocutionary effects depending on its purpose and as such, audience can only be defined in relation to the illocutionary act itself and its intended aim.[111] Thus, while Vuori maintains that audience is central to determining the success of a securitization, that audience does not exist prior to the speech act, but rather is determined by it.

In addition to providing a means of systematically applying securitization theory to different empirical settings, the significance of Vuori's approach is that it opens up securitization to the possibility of multiple audiences and various stages of success of a securitizing move. A successful securitization is thus not understood as a binary condition, but rather as operating on a continuum. A securitizing argument could thereby be accepted

[108] Balzacq, 'A theory of securitization', pp. 8-9.
[109] See Vuori, 'Illocutionary Logic and Strands of Securitization', p. 76.
[110] Vuori, 'Illocutionary Logic and Strands of Securitization', p. 72.
[111] Vuori, 'Illocutionary Logic and Strands of Securitization', p. 72.

by one audience while not achieving the same degree of success by another.[112] However, while there is value in Vuori's approach, the constitution of audience as secondary to the securitizing actor through its bringing into being by the performative intention of the speech act is ill-suited to the context of the European Union. In the case of the highly institutionalized setting of the EU, the actors engaged in any securitizing process are already pre-determined. As such, the form that a securitizing move will take will already be conditioned by the structured relationship between the three EU institutions and the rules that dictate their interactions. What is interesting for the purposes of this thesis, then, is how these institutions – in particular, the European Commission – are able to put forward securitizing arguments as a means of promoting a particular course of action given these institutional constraints. The approach to the speech act adopted for the purposes of this thesis is thereby one that follows in line with Balzacq's reading. Audience is thus constituted prior to the speech act and plays a fundamental role in not only determining the success of a securitization, but also, in this case, shaping the securitization process itself.

On this point, and bringing in the significance of setting in particular, Mark Salter has argued for the need to focus on different sociological, political, bureaucratic and organizational context as well as different national and psycho-cultural dispositions in order to account for how different audiences – whether public, elite, technocratic or scientific – 'accept' the securitization of specific issues.[113] In so doing, Salter builds upon Balzacq's focus on the social aspects of securitization to also bring to the fore the manner in which particular settings will not only structure how a securitizing actor communicates to a

[112] Vuori, 'Illocutionary Logic and Strands of Securitization', pp. 72-3. This insight is similar to McInnes and Rushton's claim that securitization functions on a continuum, different audience members occupying various positions along it. Unlike Vuori, however, McInnes and Rushton follow an approach that locates audience prior to the speech act. McInnes & Rushton, 'HIV/AIDS and securitization theory', p. 3.
[113] Salter, 'Securitization and desecuritization', p. 326.

particular audience, but also how differentially situated audiences will receive a given securitizing claim. Drawing from dramaturgical theory, Salter has thus suggested classifying securitizing moves according to setting as well as the specialized language and common conventions that characterize them: 'In each of these settings, the core rules for authority/knowledge (who can speak), the social context (what can be spoken), and the degree of success (what is heard) vary.'[114] Similar to Vuori, then, Salter provides for the possibility of a securitization to be met with various degrees of success depending on how the audience(s) concerned receives the securitizing claim. However, while Vuori places emphasis on the linguistic function of the speech act in generating audience through particular forms of securitizing moves, Salter highlights how the situatedness of particular audiences will shape the form, content and success of a securitizing claim.[115]

The significance of Salter's approach for the purposes of this thesis, then, is that it provides the grounds for considering how an institutionalized setting like the EU shapes the form that a securitizing move can take, as dictated by restrictions in mandate or institutional capacity, the relations of power between the three EU institutions and bureaucratic processes of decision-making. Moreover, it allows for an analysis of securitization processes that necessarily follow a longer temporal trajectory than that encapsulated by the moment of the speech act alone, making allowances for the possibility of multiple audiences at various stages of a securitizing process. While this thesis is focused on the interactions between the three EU institutions specifically and thereby does not consider audience below or beyond the level of the EU, the bureaucratic nature of decision-making at EU level does suggest that processes of securitization will be prolonged in nature and marked by

[114] Salter, 'Securitization and desecuritization', p. 322.
[115] Salter, 'Securitization and desecuritization', p. 322.

various stages of success. What remains to be clarified for the purposes of this thesis, then, is how these various stages of success are to be determined.

On this point, Balzacq has asserted that a securitizing actor's claims are responsive to two types of support: formal and moral. While moral support is generally necessary in supporting a securitizing actor's argument, Balzacq maintains that it is not sufficient in and of itself. Rather, formal support from an institution with 'a *direct causal connection* [emphasis original] with the desired goals' of the securitizing actor is necessary.[116] These two forms of support are thus not necessarily congruent, but rather 'are unequally distributed depending on whether the target audience is a formal institution.'[117] While a broader public audience may provide moral support for a particular securitizing claim, without the formal support of an institution that can mandate the securitizing actor to take a particular course of action, the securitizing actor's claim cannot be considered successful. The success of a securitization, then, rests with the empowered audience defined previously.

Building on Balzacq, Paul Roe has argued that the distinction between formal and moral support can be broken down into two further stages: the 'stage of identification', where an issue is identified as a security issue, and the 'stage of mobilization', where responses to the issue are established. Roe thus elaborates on Balzacq's distinction by arguing that while an audience may agree on the 'securityness' of a particular issue, that same audience may disagree over the 'extraordinariness' of the proposed action to be taken in response: 'Such a situation is not an example of failed securitization (as the audience did not reject the issue as 'security'), but nor is it a successful securitization, as the means

[116] Balzacq, 'The Three Faces of Securitization', pp. 184-5.
[117] Balzacq, 'The Three Faces of Securitization', p. 184.

necessary to deal with the issue are not also intersubjectively established.'[118] For Roe, this two-stage process demonstrates 'the importance of the actual *employment of emergency measures* [emphasis original] in defining the securitization concept.'[119] Roe states: '[T]he relationship between actor and audience is thus constituted not only in accordance with whether the support required is either moral or formal, but also in accordance with what the audience is being asked to agree with: "this is a threat" and/or "given that this is a threat, this is what I propose we do about it.'[120]

The distinction between formal and moral support as well as support for the securityness of a particular issue versus mobilization in response to that issue provides an inroad into accounting for the various stages of success of a securitization at the level of the EU. As the focus of analysis in this thesis is on the interrelation between the three EU institutions in the process of securitizing pandemic influenza, the thesis is necessarily interested in accounting for the formal support provided by an empowered audience for a securitizing claim. However, the distinction between support for the 'securityness' of pandemic influenza and collective mobilization in response to the identified threat is an important one, particularly given that public health remains primarily in the domain of Member States. While the 'securityness' of pandemic influenza may be broadly recognised by the EU and its Member States, what is interesting for the purposes of this thesis is whether the claim to the securityness of pandemic influenza necessarily translates into collective action at the level of the EU and if so, what form this collective action takes. Distinguishing between the 'stage of identification' and the 'stage of mobilization' thereby

[118] Roe, 'Actor, Audience(s) and Emergency Measures', p. 616.
[119] Roe, 'Actor, Audience(s) and Emergency Measures', p. 620.
[120] Roe, 'Actor, Audience(s) and Emergency Measures', p. 622.

provides a means of differentiating the various stages of securitization at the level of the EU and brings to the fore the inherently political nature of this process.

With the previous section on the significance of context in the establishment of security meaning in mind, then, this section has argued for a perlocutionary reading of the speech act as a means of accounting for audience in the securitization process. Audience is thereby situated prior to the speech act and emphasis is placed on the role of audience in shaping the form, content and possible outcomes of a securitizing move. The success of a securitizing move is ultimately determined by the collective willingness to act on a securitizing claim, the support for a securitizing claim being broken down into two stages – what Roe has labelled the 'stage of identification' and the 'stage of mobilization.' Security meaning is thus not determined by the speech act itself, but is co-constituted by context, the situatedness of audience playing a central role in both determining the success of a securitizing move and shaping the form that a securitizing move may take.

Conclusion: A blueprint for securitization theory's empirical application

The EU is a context distinct from that of the structured domestic political setting underpinning the Copenhagen School's theory of securitization. The absence of a clear distinction between actor and audience and the lack of sovereign capacity, along with the continually evolving role of the EU as an economic and political entity, means that the location of security meaning in the moment and logic of the speech act is ill-suited to capturing securitizing dynamics in this context. This chapter has therefore argued for the need to move beyond the centrality of the speech act in delineating security if the Copenhagen School's theory of securitization is to have empirical purchase at EU level. In so

doing, the chapter has argued for a reorientation of securitization theory away from the Copenhagen School's normative agenda to recognise securitization as what Balzacq has labelled a 'strategic (pragmatic) practice'. The speech act is thereby understood as a strategic act of persuasion, the goal of which is to convince an audience to take a customized course of action based on an argument employing a particular security logic – that of extreme or existential threat and priority for action. Such an approach enables an opening up of securitization theory to different empirical settings by not only providing an avenue to move beyond the dichotomy between politicization and securitization signalled by the criterion of exceptionality in the Copenhagen School's framework, but also by elevating the significance of both audience and context in determining the meaning of security – two aspects that this chapter has argued are vital in identifying processes of securitization at the level of the EU.

The chapter has argued that context is relevant in accounting for securitizations at the level of the EU in two respects: First, as it pertains to the role that external contextual developments play in giving credence to securitizing claims made and to the audience's frame of reference; and second, as it pertains to the institutional setting itself and the rules that govern actor-audience interaction and how securitizations are able to take form. The first point is particularly relevant in the case of pandemic influenza as its cyclical nature suggests that the relative success of its securitization would be dependent on the perceived criticality of the moment in which the securitizing attempt took place. However, the chapter has also suggested that context matters in accounting for how practices of security alter over time, such as with the convergence of the fields of health and security, and in different institutional contexts, as suggested by the second point. Context thus determines what

exceptionality entails in a given setting. In the case of the EU, where securitizations are likely to take the form of a process rather than an event, and where the idea of 'normal' politics continues to evolve over time, exceptionality necessarily has to be understood as context-bound.

The chapter has argued that audience itself plays a vital role in the securitization process by not only determining the success of a securitizing claim, but also shaping the form that a securitizing move may take, as dictated by the audience's positional role in relation to the securitizing actor. In the case of the EU, the actors involved in the securitization process are already pre-determined and as a consequence, the form that a securitizing move takes will already be conditioned by the structured relationship between the EU institutions. The chapter has thus argued that audience necessarily exists prior to the speech act and in the case of the institutions of the EU, can be considered an 'empowered' one. Following Roe, moreover, the chapter has argued that the success of a securitization is not determined by the audience's acceptance of the 'securityness' of a specific issue, but rather by its willingness to collectively act on a securitizing claim. This is particularly relevant in the EU context where public health is primarily a Member State competence. Therefore, while Member States may agree to the securityness of pandemic influenza, they may not necessarily agree to collective action at EU level.

The chapter has thus asserted that securitizations at the level of the EU can be identified by a two-part process of locating securitizing moves as signalled by a rhetorical structure that draws on a particular security logic, and by identifying measures implemented in response to these securitizing moves. Drawing from Ciută, the chapter has argued that exceptionality is thus determined on the basis of those practices that have been put in place

to respond to a particular securitizing call. These practices themselves hold constitutive force in that they provide a new basis for new security iterations and possible measures to follow. The success of these iterations at any point in time, however, is dependent on the collective willingness to act on them. In the case of the EU, the relative success of the securitizing process can be measured on the basis of the expansion of competences and activities at EU level in response to preceding securitizing claims, such as the creation of new bodies and institutions at EU level or new tools or instruments aimed at addressing the perceived threat. The process of securitization at the level of the EU can therefore be measured by focusing on clusters of security rhetoric and practice over time. This not only enables the possibility of accounting for the different stages of development characterizing a particular securitizing process, but also enables one to account for securitizing moves and their outcomes despite potential ambiguity over the differentiation between actor and audience and the directional force of a securitizing claim.

On the basis of these insights, the chapter has provided a revised approach to securitization theory amenable to examining the process of securitizing pandemic influenza at the level of the EU. The thesis thus proceeds by drawing from this theoretical framework in undertaking the empirical analysis. Chapter two begins by establishing the context in which the process of securitizing pandemic influenza at the level of the EU can be situated. It does so by first, establishing the broader international context in which the rise of an EU role in public health has emerged, and second, by outlining the key developments at the level of the EU that set the parameters for securitizing dynamics evidenced in subsequent chapters. On the basis of this, chapters three, four and five trace the process of securitizing pandemic influenza at the level of the EU. Chapter three identifies the relevant actors

engaged in any securitizing dynamics at EU level as well as any securitizing moves and their outcomes in the period leading up to the 2009 influenza A(H1N1) pandemic. Chapter four focuses specifically on the 2009 influenza A(H1N1) pandemic and its impact on the securitization process documented up to that point in time, while chapter five analyses the legislative proposal for a Decision on serious cross-border threats to health in light of the previous chapters as a means of determining whether pandemic influenza can indeed be considered securitized at the level of the EU and if so, what precisely this securitization entails.

Chapter 2: Pandemic influenza in context: the evolution of a health security agenda in the EU and internationally

Introduction

This is the first of four chapters that empirically examines the securitization of pandemic influenza at the level of the EU. The purpose of this chapter is to establish the broader context in which securitizing dynamics evidenced at EU level are situated in order to be able to adequately account for the process of securitizing pandemic influenza in the Union. The aim of the chapter is two-fold: First, to trace the evolution of the term health security in global health discourse as a means of accounting for its meaning and strategic importance; and second, to examine the European Union institutional context and the emergence of an EU role in public health given these broader contextual developments.

In keeping with the orthodoxy, the chapter argues that over the course of the past 20 years, the relationship between global health and security has taken on renewed significance. This is the outcome of two factors: First, the end of the Cold War resulted in a series of conceptual shifts over the meaning of security that provided a space for health issues to be considered as security concerns. Second, this same time period also resulted in a growing awareness of a number of new health risks. This awareness was brought about by the emergence and resurgence of a number of infectious diseases that focused international attention on the risks posed by the microbial world. The intensification of processes of globalization also brought to the fore the interconnected nature of vulnerability post-Cold

War and a growing sense of the world as 'a single epidemiological community.'[121] These two factors have contributed to the rise of the notion of health security, both as a rhetorical device used by academics and practitioners to garner attention and resources to address these newly recognised health concerns, and as a means of intervening on these health issues.

The concept of health security, however, is a contested one, its meaning differing depending on the values, interests and identities of the actors involved in its promotion. Health security has thus been used to reflect what this chapter identifies as three broad approaches to the security-health nexus: health security as a component of human security; health security as approached from the standpoint of global public health; and health security as a manifestation of national or international security.[122] While each of these approaches functions slightly differently with respect to the underlying purpose of the evocation of the term, permeating all three approaches are a number of underlying themes. These include a concern with vulnerability, a recognition of an increasingly interconnected world demanding transnational collaboration in health security provision, and a focus on prevention as at least one of the necessary tools in providing for health security. The

[121] Ingram, A. 'Pandemic Anxiety and Global Health Security', in *Fear: Critical Geopolitics and Everyday Life*, edited by Rachel Pain & Susan J. Smith (Aldershot, Ashgate, 2008), p. 75.

[122] It should be noted that the term biosecurity is also often used in discussions regarding the interlinkages between security and health. As with the term 'health security', the meaning of biosecurity differs depending on its usage and can refer to anything from concerns with biological weapons and biodefense, including issues concerning the prevention of life sciences research and biological agents from laboratories being used for harmful purposes (see, for example, Collier, S. J., A. Lakoff & P. Rabinow. 'Biosecurity: Towards an anthropology of the contemporary', *Anthropology Today* 20(2004), pp. 3-7; Enemark, C. 'Law in the time of Anthrax: Biosecurity Lessons from the United States', *Journal of Law and Medicine* 17(2010), pp. 748-60), to protecting flora and fauna from infection (see, for example, Barker, K. 'Flexible boundaries in biosecurity: accommodating gorse in *Aotearoa* New Zealand', *Environment and Planning A* 40(2008), pp. 1598-1614; Enticott, G. 'The spaces of biosecurity: prescribing and negotiating solutions to bovine tuberculosis, *Environment and Planning A* 40(2008), pp. 1568-1582) to efforts to secure health more broadly (see, for example, Lakoff, A. & S. J. Collier (eds). *Biosecurity Interventions: Global Health and Security in Question* (New York, Columbia University Press, 2008). For the purposes of this chapter, to the extent that the term biosecurity is used, it falls under the umbrella of national and international security concerns and is used in relation to the threat of the deliberate release of biological agents.

boundaries between the three approaches, moreover, are blurred, the language of one often converging with or being evoked by another.

While all three of these approaches to health security feature in academic and policy discussions on the security-health link, the chapter asserts that it is the promotion of health security as a matter of national or international security that has held particular salience over the course of the past 20 years. This can be attributed to three interrelated factors. First, a number of outbreak events have reinforced a sense of international vulnerability to disease emergence and reconfigured conceptualizations of insecurity at the national level. Second, state interest continues to play an important role in shaping the international agenda. Third, the human security and global public health approaches to health security have not been able to provide operationally distinct alternatives to health security as a matter of national or international security. The result has been a predominant engagement with health security in conceptually narrow terms, the focus falling primarily on managing the mobility of those diseases that are perceived to carry the capacity to disrupt the stability of the state and the international system.

These international developments have held bearing for the rise of an EU role in public health. On this point, the chapter argues that three interrelated factors have influenced the development of EU-level competences in providing for public health protection: the growing international preoccupation with the security risks associated with the microbial world post-Cold War, reinforced by a number of new health challenges that have emerged within this time period; the presence and influence of a number of international bodies engaged with various aspects of health security provision; and the interconnection between communicable disease management and the EU integration

project. The EU has emerged as an additional site where questions over jurisdiction and responsibility in managing the global circulation of infectious diseases are being played out. Health security as articulated and practiced in the EU context has reflected the narrow approach to health security that has predominated internationally and has primarily focused on ensuring the economic and political integrity of the Union as a whole, including protecting EU citizens from health threats. Given the close interrelation between the rise of health security internationally and the evolving role of the EU as a health security provider, moreover, it is clear that pandemic influenza has not been institutionalized as a security threat prior to EU engagement in the field of public health.

The significance of these findings for the purposes of this thesis is two-fold: First, they support the choice of securitization theory as a theoretical framework guiding the empirical study. This is not only because securitization theory provides a means of accounting for the widening of the security agenda without the deepening of the term, but also because it highlights the strategic or pragmatic use of language in bringing about the goals of a particular actor. In the case of health security, the use of the term in all three approaches to the security-health nexus has served a strategic or pragmatic purpose, although it is the (inter)national security approach to health security that has held particular salience. Moreover, in the case of the EU in particular, the rise of an EU health security agenda has been closely tied to the assertion of a distinct role for the EU in the domain of public health. On this point, the evolution of the EU's role as a health security provider cannot be separated from developments internationally as the additional competences acquired at EU level are in part an outcome of the broader growth of health security thinking worldwide. Second, these developments provide the contextual backdrop that set

the conditions for the process of securitizing pandemic influenza at the level of the EU. In this respect, they contribute to establishing what Balzacq has referred to as the contextual effects or the 'relevant aspects of the *Zeitgeist*' that influence the success of a securitization.[123]

The chapter begins by examining the various manifestations of the term health security and how it has been utilized by actors internationally, focusing on key shifts in the security-health link over time. Next, attention turns to the institutional context of the European Union and the emergence of an EU role in public health. The chapter concludes with a discussion of the relevance of these developments for the examination of the process of securitizing pandemic influenza at the level of the EU in subsequent chapters.

Health security and the international context: Raising the issue of health on the international political agenda

The link between health and security is not novel, health having been enshrined as fundamental to peace and security in the World Health Organization (WHO)'s constitution in 1946.[124] However, whereas by the mid-20th century medical and public health experts generally considered infectious diseases as conquerable with time, the identification of a number of new diseases toward the turn of the millennium, along with the resurgence of old ones in more volatile forms, refocused attention to the vulnerabilities associated with the microbial world.[125] Outbreaks of Ebola amongst monkeys in a US research facility in 1989 and amongst humans in the Democratic Republic of Congo (formerly known as Zaire)

[123] Balzacq, 'The Three Faces of Securitization', p. 192.
[124] World Health Organization. *Constitution of the World Health Organization* (Geneva, World Health Organization, 1946), p. 130.
[125] Ingram, 'Pandemic Anxiety and Global Health Security', p. 76.

in 1995, the outbreak of Plague in India in 1994, the identification of multi-drug resistant forms of Tuberculosis, and more prominently, the emergence and spread of HIV/AIDS, all served as key developments that raised the risks posed by infectious disease on the international political agenda.

At the same time, the end of the Cold War and the broadening of the security agenda that accompanied it provided the conceptual space for the links between security and health to be explored in more detail. No longer restricted to inter-state military rivalry, the post-Cold War environment bore witness to the rise of a number of new security concerns that encompassed alternative forms of conflict and a wider range of recognised vulnerabilities related to issues of health, environment and economy.[126] The intensification of processes of globalization, driven by economic and political liberalization as well as the development of new forms of information and communication technology also underscored the interconnected nature of vulnerability and insecurity post-Cold War.[127] As a consequence, the past 20 years has resulted in a renewed awareness of the linkages between security and health.

This broadening of the security agenda has been reflected in three broad approaches to the security-health nexus that have emerged and evolved over the course of the past 20 years: health security as a matter of human security; health security as a matter of global public health; and health security as a matter of national or international security. Whereas the first two approaches generally fall into what Sara Davies has identified as a 'globalist' understanding of the interrelation between security and health, reflecting as they do a

[126] For an introduction to these issues, see Owen, T. 'Human Security: A Contested Concept', in *The Routledge Handbook of New Security Studies*, edited by J. Peter Burgess (London & New York, Routledge, 2010), p. 39.
[127] See Fukuda-Parr, S. 'New Threats to Human Security in the Era of Globalization', in *Human Insecurity in a Global World*, edited by L. Chen, S. Fukuda-Parr & E. Seidensticker (Cambridge, MA & London, Harvard University Press, 2003), pp. 1-3.

concomitant deepening of the security agenda to account for manifestations of insecurity beyond the level of the state, the latter approach to health security – or what Davies has called the 'statist' approach – focuses primarily 'on public health as a means through which the stability of the state can be assured.'[128] However, whereas in the instance of human security, health security is one means of achieving the realization of the security of the individual, in the case of global public health security, the directional emphasis is on how health security can ensure the health of the population.

Thus, while all three approaches share commonalities with respect to themes of growing vulnerability to a broadening array of health challenges in an increasingly globalized world and the need for cross-border collaboration to mitigate them, the interests underpinning the evocation of health security in each instance differ. Nevertheless, as will be demonstrated below, the distinction between these three approaches is often blurred, the language of one often converging with or being evoked by another. Moreover, over the course of the past 20 years, it is the national or international security approach to health security that has dominated the international agenda, the human security and global public health approaches having failed to provide operationally distinct alternatives to health security's predominant framework. The evolution of each of these approaches will be discussed in turn.

Health and (inter)national security

The growing preoccupation with health as a matter of national or international security following the end of the Cold War has been shaped by three developments in particular: the

[128] Davies, S. E. *Global Politics of Health* (Cambridge & Malden, MA, Polity, 2009), pp. 23, 9.

scale and spread of HIV/AIDS, particularly in sub-Saharan Africa; the emergence of new infectious diseases and the resurgence of old ones in more volatile forms; and a concern with the threat posed by biological weapons, particularly the possibility of bioterrorism.[129] The increased density of global interconnectivity associated with processes of globalization has served to fuel a sense of vulnerability associated with all three, sound public health infrastructure in one state no longer recognised as in itself enough to provide protection against threats associated with the microbial world.[130]

The potential transboundary nature of the instability generated by these three developments, moreover, has blurred the distinction between national and international security. The link between health and national or international security has thereby been argued along three lines: first, on the basis of the capacity of disease to threaten international stability, either through negatively impacting the global economy, through the instigation of migration flows or through impacting the operational capacity of militaries and peacekeeping forces; second, on the basis of the capacity of disease to disrupt the economic and political stability of the state; and third, on the basis of the capacity of disease to create high rates of morbidity and mortality.[131] Indeed, Andrew Lakoff has argued that the concern with emerging infectious diseases that arose in the late 1990s along with concerns about the possibilities of bioterrorism has resulted in a gradual shift in security provision away from a focus on the population or the national territory to 'the critical

[129] Fidler, D. P. 'Public Health and National Security in the Global Age: Infectious Disease, Bioterrorism, and *Realpolitik*', *George Washington International Law Review* 35(2003), pp. 791-2; Heymann, D. 'Infectious Disease Threats to National and Global Security', in *Human Insecurity in a Global World* edited by L. Chen, S. Fukuda-Parr & E. Seidensticker (Cambridge, Harvard University Press, 2003), p. 196.
[130] Elbe, *Security and Global Health*, pp. 31-2.
[131] McInnes & Lee, *Global Health and International Relations*, pp. 148-54.

systems that underpin social and economic life' – what he has identified as vital systems security.[132]

While not an outcome of national or international security concerns itself, a key point in the evolution of the health-(inter)national security link took place on 1 May 1989, when scientists and public health experts convened at a conference co-organised by the United States National Institutes of Health and Rockefeller University to discuss concerns regarding the relatively recent appearance of new diseases, such as HIV/AIDS and Ebola, and the emergence of antimicrobial resistance amongst known ones.[133] The conference marked the beginnings of what Nicholas B. King has labelled the 'emerging diseases worldview' and culminated in an influential volume entitled *Emerging Viruses* and edited by virologist and immunologist Stephen Morse.[134] The views expressed at the conference provided the basis for what would become 'an orthodox set of predictions and recommendations that would later be picked up by a wider group that included other scientists, prominent journalists, local and national public health officials, and, eventually, national security experts.'[135]

Indeed, the link between these emerging diseases and security was taken up and promoted by academics and journalists alike, developed further through scholarship over subsequent years. The publications by Laurie Garrett and Richard Preston are of particular note in this regard, as they played a prominent role in drawing public attention to the threat

[132] Lakoff, A. 'From Population to Vital System: National Security and the Changing Object of Public Health', in *Biosecurity Interventions: Global Health and Security in Question*, edited by Andrew Lakoff & Stephen J. Collier (New York, Columbia University Press, 2008), pp. 48, 36-7.
[133] King, N. B. 'Security, Disease, Commerce: Ideologies of Postcolonial Global Health', *Social Studies of Science* 32(2002), p. 766.
[134] Morse, S. (ed.). *Emerging Viruses* (New York, Oxford University Press, 1993); King, 'Security, Disease, Commerce', p. 767.
[135] King, 'Security, Disease, Commerce', p. 767.

posed by emerging infectious diseases.[136] Scholarly engagement with the disease-national or international security link for its part focused on the threat that infectious diseases pose to state power and authority, national and international economic and political stability, peacekeeping forces and the armed forces of the state, health in this instance understood as the absence of disease.[137] However, as Colin McInnes and Kelley Lee have noted, the causal relationship between many of the claims initially made between health and national or international security has often been questionable and robust empirical evidence to support these claims has often been lacking.[138] Recent scholarship has thereby attempted to take into account the complex array of factors that shape the disease-(inter)national security relationship, acknowledging the case-sensitivity and context-specificity of the manifestations of threat.[139] These developments are notable given the prominence of the health and (inter)national security narrative in shaping international engagements with health security and bring to the fore the question of strategic purpose in the evocation of the term.

The United States has been at the forefront of promoting the link between health and national or international security, both domestically and on the international scene. Within the United States, the issues raised at the 1989 conference were picked up in a report published by the United States Institute of Medicine (IOM) in 1992. Entitled *Emerging*

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[136] See Garrett, 'The Return of Infectious Disease'; Garrett, L. *The Coming Plague: Newly Emerging Diseases in a World Out of Balance* (New York, Penguin, 1995)*;* Preston, R. 'Crisis in the Hot Zone', *The New Yorker* October 26, 1992, p. 58; Preston, R. *The Hot Zone* (New York, Anchor Books, 1995).

[137] See, for example, Ostergard, Jr., 'Politics in the hot zone'; Osterholm, 'Preparing for the Next Pandemic'; Singer, 'AIDS and International Security'; Elbe, 'HIV/AIDS and the Changing Landscape of War in Africa'; Enemark, 'Pandemic Pending'; Enemark, 'Is Pandemic Flu a Security Threat?'; Huang, 'In-Flew-Enza'; Price-Smith, 'Ghosts of Kigali'; Price-Smith, *The Health of Nations*; Pirages, D. *Microsecurity: Disease Organisms and Human Well-Being*, report issued by Woodrow Wilson Centre Environmental Change and Security Project (1996).

[138] McInnes & Lee, *Global Health and International Relations*, pp. 149-55.

[139] See, for example, Enemark, *Disease and Security*, p. 1; Huang, 'In-Flew-Enza', p. 146; Price-Smith, *Contagion and Chaos*, p. 199.

Infections: Microbial Threats to Health in the United States, the report made the threat posed by emerging infectious diseases to the United States explicit:

> As the human immunodeficiency virus (HIV) disease pandemic surely should have taught us, in the context of infectious diseases, there is nowhere in the world from which we are remote and no one from which we are disconnected. Consequently, some infectious diseases that now affect people in other parts of the world represent potential threats to the United States because of global interdependence, modern transportation, trade, and changing social and cultural patterns.[140]

The IOM report marked the beginning of a US focus on the threat of emerging infectious diseases to national and international security and set the basis for claims to the link in years to come. In June 1996, US President Bill Clinton issued a US Presidential Decision Directive that officially recognised emerging diseases as a threat to national security and established a national policy to address them. This included a focus on improved surveillance both domestically and on a global scale as well as other measures aimed at prevention and response.[141]

As part of the response to the Presidential Decision Directive, in 1999, the United States National Intelligence Council produced its National Intelligence Estimate, *The Global Infectious Disease Threat and Its Implications for the United States*, declassified in January 2000. The aim of the report was to delineate the threat posed by various diseases to the United States, its military overseas, and to regions of strategic interest. While maintaining that the infectious disease burden would be felt most heavily by developing and former

[140] Institute of Medicine. *Emerging Infections: Microbial Threats to Health in the United States* (Washington, National Academy Press, 1992), p. v.
[141] The White House Office of Science and Technology Policy. *Fact Sheet: Addressing the Threat of Emerging Infectious Diseases*. 12 June 1996. Available from: http://www.fas.org/irp/offdocs/pdd_ntsc7.htm [Accessed on 18 September 2013].

communist countries, and particularly sub-Saharan Africa, the report claimed that infectious diseases also constituted a threat to US security given the country's position as a hub of international mobility as well as its large civilian and military presence abroad. As such, the United States was considered 'at risk from global infectious disease outbreaks, or even a bioterrorist incident using infectious disease microbes.'[142] The report maintained that emerging infectious diseases would pose a rising threat to US and global security over time, endangering US citizens, threatening US armed forces, and exacerbating social and political instability in areas of key strategic interest.[143]

A pivotal moment in the advancement of the disease-(inter)national security claim occurred in January 2000 when the United Nations Security Council took up the issue of the potential impact of HIV/AIDS on peacekeeping operations in a Special Session on HIV/AIDS – the first time in history that the UN Security Council discussed the consequences of disease for international peace and security. US Ambassador Richard Holbrooke, and Director of UNAIDS, Peter Piot, played instrumental roles in acquiring the consensus needed for the Security Council to adopt Resolution 1308 on 17 January 2000, which focused on the vulnerability of peacekeeping forces to HIV/AIDS and the possibility of these forces serving as vectors in spreading the disease further.[144] Colin McInnes and Simon Rushton have argued that the engagement of the Security Council with the issue of HIV/AIDS and the

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[142] National Intelligence Council, *National Intelligence Estimate: The Global Infectious Disease Threat*, p. 53.

[143] National Intelligence Council, *National Intelligence Estimate: The Global Infectious Disease Threat,* p. 5. The 2008 declassified US National Intelligence Estimate entitled *Strategic Implications for Global Health* marked an interesting departure from the declassified Estimate of 2000 by expanding its focus to include a broader array of public health challenges. While the report maintained that HIV/AIDS, pandemic influenza and new and emerging infectious diseases posed the most direct threat to the United States, it made the marked step of also claiming that such challenges as maternal mortality, malnutrition, chronic diseases and other non-infectious health concerns were also of US interest given their impact on economies, governments and militaries in countries and regions of strategic significance. National Intelligence Council, *Strategic Implications of Global Health*, p. 2. The report thus appealed to human security and development concerns, yet maintained a national security frame of reference by focusing on areas of strategic significance.

[144] United Nations Security Council. *Resolution 1308 (2000)*. S/RES/1308 (2000), 17 July 2000.

passing of UNSC Resolution 1308 six months later marked a significant development in engagements with HIV/AIDS as a matter of security, adding weight behind the HIV/AIDS-security claim and paving the way for subsequent debate and action on the issue. These events, according to McInnes and Rushton, signalled a clear shift from framing HIV/AIDS as a matter of development or public health, to that of a threat to national security.[145] The Security Council took up the issue of HIV/AIDS in subsequent sessions in 2001, 2003, 2005 and 2011.

A turning point in the growing preoccupation with emerging infectious diseases and national or international security occurred, however, when in October 2001 – the month following the 11 September 2001 terrorist attacks in the United States – anthrax was sent through the mail to members of the US Congress. While the possibility of bioterrorism was already of international concern following the collapse of the Soviet Union and the uncertainties that it raised about the fate of its biological weapons research, the 2001 anthrax attacks put public health 'onto the frontline of homeland security.'[146] The anthrax attacks marked a clear convergence of the threat of infectious disease with traditional national security imperatives, underscoring the utility of a robust public health capacity both domestically and globally in not only detecting and containing naturally emerging diseases, but also in defending against the possibility of a deliberate biological attack.[147]

The attacks thus provided the impetus behind the creation of the Global Health Security Initiative (GHSI), initially envisaged by former US Secretary General of Health and Human Services, Tommy Thompson, as a means of bringing like-minded countries together

[145] McInnes & Rushton, 'HIV, AIDS and security', p. 228.
[146] Ingram, 'Pandemic Anxiety and Global Health Security', p. 77.
[147] Heymann, D. 'Infectious Disease Threats to National and Global Security', pp. 195-6, 202, 206; See also Fidler, D. 'Public health and national security', p. 788.

to coordinate information and activities to counter the possibility of bioterrorism. Made up of Canada, the European Union, France, Germany, Italy, Japan, Mexico, the United Kingdom and the United States, the GHSI had the initial aim of strengthening global public health preparedness and response mechanisms to counter the threat of chemical, biological, radiological or nuclear (CBRN) terrorism. Global health security in this context was narrowly conceived and focused on the national security threat posed by terrorism of catastrophic potential, although in 2002, the mandate of the GHSI was broadened to incorporate the threat of pandemic influenza.

The outbreak of Severe Acute Respiratory Syndrome (SARS) in 2002-2003 signalled a further shift in the relationship between disease and security, the impact that SARS had on the economy of Toronto demonstrating that even countries with developed health care capacities remained vulnerable to the microbial world. As Stefan Elbe has pointed out, SARS signalled that it was now 'possible legitimately to view any disease with the potential to cause significant mortality and economic damage as a national security threat.'[148] This possibility was reinforced with the resurgence of the highly pathogenic H5N1 avian influenza virus in 2004-2005 and concerns over its potential to mutate to achieve sustained human-to-human transmission. In a speech given to the US National Institutes for Health in 2005, then-US President George W Bush described the possibility of an influenza pandemic as not just a 'vital issue to the health and safety of all Americans', but also a 'danger to our homeland', arguing that the global consequences that an influenza pandemic would carry meant that 'no nation can afford to ignore this threat.'[149]

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[148] Elbe, *Security and Global Health*, p. 46.
[149] US Department of State. *President Outlines Pandemic Influenza Preparations and Response*. 1 November 2005. Available from: http://2001-2009.state.gov/g/oes/rls/rm/55882.htm [Accessed on 18 September 2013].

At a speech delivered to the UN General Assembly that same year, President Bush announced the creation of the International Partnership on Avian and Pandemic Influenza (IPAPI) as a means of fostering international collaboration in preparing for and responding to an influenza pandemic. Thomas Abraham has argued that the creation of IPAPI marked an important step in promoting pandemic influenza as a security issue internationally, a series of ministerial meetings led by the United States serving to reinforce pandemic influenza as 'a disease that required urgent international action because of the threat it posed to global society.'[150] As Elbe has noted, the possibility of an influenza pandemic took the relationship between health and security one step further, locating threat in the contingency of the future and reorienting security around the need to prepare for that which has yet to occur.[151] This shift in emphasis is emblematic of the increased attention paid to what Lakoff has identified as vital systems security over the course of the past 20 years, the provision of health security in this context gradually shifting from a focus on prevention to that of preparedness.[152]

The emerging infectious diseases narrative that gained prominence in the 1990s was thus central to the evolution of the notion of health security as understood from the standpoint of national and international security. The renewed preoccupation with communicable disease emergence at the beginning of the 1990s, spurred by a number of outbreak events, led academics, journalists and policymakers alike to advance claims as to the threat posed by infectious diseases to the stability of the state and the international system. The 2001 anthrax attacks followed by the outbreak and spread of SARS in 2002-2003 and the resurgence of the H5N1 avian influenza virus in 2004-2005 reinforced these

[150] Abraham, 'The Chronicle of a Disease Foretold', p. 801.
[151] Elbe, *Security and Global Health*, p. 33.
[152] Lakoff, 'From Population to Vital System', p. 34.

claims, bringing the fields of health and security closer together and reorienting the focus of security provision away from prevention alone to focus increasingly on that of preparedness. The renewed attention paid to the threat of pandemic influenza was significant in this regard as, according to Lakoff, it became ‘a vehicle for a more general form of planning – one oriented toward a variety of potential threats.’[153]

The strength of the national or international security narrative in international engagements with global health, moreover, is notable given the lack of robust empirical evidence demonstrating the link. This suggests, as Abraham has noted with reference to pandemic influenza in particular, that the elevation of particular diseases onto the national security agenda has not been ‘a straightforward response to developments in the natural world, but [has been] mediated and socially constructed by actors and institutions.’[154]

Health security and global public health

While the focus of the national or international security approach to health security has primarily been on the impact that infectious disease outbreaks carry for the critical functioning of the state and the international system, health security as approached from the standpoint of global public health is primarily concerned with the structural conditions that determine health outcomes. The referent object of health security in this context is the health of the population, health defined as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.’[155] Thus, while both the human security and (inter)national security approaches to the security-health nexus are

[153] Lakoff, ‘From Population to Vital System’, p. 34.
[154] Abraham, ‘The Chronicle of a Disease Foretold’, p. 799.
[155] World Health Organization, *Constitution of the World Health Organization.*

primarily preoccupied with how health impacts security, in the global public health context, the focus of health security is on how the globalization of health risks impacts health.[156] As Niamh Stephensen has stated, 'security is not presented as a mere dimension of or justification for the work of public health; it *is* [emphasis original] public health.'[157] Consequently, as McInnes and Lee have pointed out, the use of the term health security in this context is not as an analytical tool, but as a strategic or pragmatic means of mobilising action to improve health globally.[158] Health security is thus conceptualized at the global level and involves a simultaneous scaling down and scaling up to focus on how the physical and social environments at both local and global levels interact to shape health outcomes.[159]

The WHO has been at the forefront of promoting health security as a matter of global public health. Arguments linking health, security and globalization began to make their appearance in WHO documents at the turn of the millennium and were developed further in following years.[160] As with the human security and (inter)national security approaches to health security, global public health security has been argued on the basis of a changed security environment post-Cold War that has been characterized on the one hand, by a broader and more complex array of threats and on the other hand, by forces of

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[156] McInnes & Lee, *Global Health and International Relations*, pp. 136-7.

[157] Stephenson, N. 'The Disappearing Act of Global Health Security' in Christian Enemark & Michael J. Selgelid (eds), *Ethics and Security Aspects of Infectious Disease Control: Interdisciplinary Perspectives* (Farnham, Surrey & Burlington, VT, Ashgate, 2012), p. 97.

[158] McInnes & Lee, *Global Health and International Relations,* p. 140.

[159] Kickbush, I. 'Think Health: What makes the difference?', *Health Promotion International* 12(1997), p. 266.

[160] Steven Hoffman has argued that the history of global health security governance can be broken down into four distinct time periods, each one characterized as follows: (1) unilateral quarantine; (2) multiple sanitary conferences; (3) international sanitary conventions and international health organizations; and (4) hegemonic leadership of the WHO. Hoffman, S. 'The evolution, etiology and eventuality of the global health security regime', *Health Policy and Planning* 25(2010), pp. 511-12. However, McInnes and Lee have argued that these four periods are indicative of increasing international cooperation in protecting national public health rather than an explicit move to a more globalized view of health security. McInnes and Lee, *Global Health and International Relations*, p. 135. This shift to a focus on the globalization of health risks does not appear until the turn of the millennium and as has been argued above, is primarily promoted by the WHO itself.

globalization that have served to reduce the temporal and spatial dimensions of insecurity.[161]

The emerging infectious diseases narrative has featured prominently in the global public health approach to health security, although infectious diseases are recognised as only one source of insecurity amongst others. Thus, a WHO report published in 2003 and entitled *Global defence against infectious disease threat* asserted that a 'shift in the perception of infectious disease threat' had taken place, a disease event in one country now recognised as constituting 'a health emergency of concern for the entire world.'[162] Written following the May 2001 World Health Assembly resolution on global health security which focused on strengthening international capacity to detect and respond to emerging infectious diseases, the 2003 WHO report identified a series of health challenges that it argued were matters of security: emerging and epidemic-prone diseases, antimicrobial resistance, bioterrorism and threats arising from neglect. Neglect in this instance referred on the one hand, to complacency that had allowed the collapse of control programmes and the resurgence of the infectious disease threat, and on the other hand, to neglected diseases, the burden posed by them having the capacity to 'threaten food security, disrupt patterns of land use, displace populations, impair mental development, reduce school attendance, and ensure that subsequent generations – poorly educated or physically or mentally disabled – remain anchored in poverty.'[163]

An article published that same year by then-WHO Director General, Gro Harlem Brundtland, followed a similar line of argumentation:

[161] World Health Organization. *Global defence against the infectious disease threat*. WHO/CDS/2003.15 (WHO, Geneva, 2003), p. 14.
[162] World Health Organization, *Global defence against the infectious disease threat*, p. 14.
[163] World Health Organization, *Global defence against the infectious disease threat*, p. 19.

> Today, in an interconnected world, bacteria and viruses travel almost as fast as e-mail and financial flows….There are no health sanctuaries. No impregnable walls exist between a world that is healthy, fed and well-nourished and one that is sick, malnourished and impoverished….Today we cannot view health solely as an issue of how many people will get ill and how many will recover, of who lives and who dies. We must look at why. And we should broaden the debate to accept that health is an underlying determinant of development, security, and global stability.[164]

Rooting her argument in an appeal to a contemporary global environment defined by its interconnectedness and mutual vulnerability, Brundtland propounded the need for enhanced international cooperation in investing in health to tackle not only emerging and resurgent infectious diseases, but also those diseases that affect those impoverished, maintaining that the functional separation between domestic and international health problems has lost its utility in an environment characterized by the transnational flow of people and goods.[165] Making reference to the 2001 anthrax attacks and the experiences with SARS, Brundtland argued that the tools needed to address these threats were also essential to detecting diseases in general, cooperation at the national, regional and global levels necessary in order to build up the capacities to provide for public health protection.[166]

The 2007 World Health Report entitled *A Safer Future: Global Public Health Security in the 21st Century*, provided the most developed account of health security as approached from the standpoint of global public health to date. Global public health security was defined in the report as 'the activities required, both proactive and reactive, to minimize vulnerability to acute public health events that endanger the collective health of

[164] Brundtland, G. H. 'Global Health and International Security', *Global Governance* 9(2003), pp. 417-18.
[165] Brundtland, 'Global Health and International Security', pp. 419-20.
[166] Brundtland, 'Global Health and International Security', p. 422.

populations living across geographical regions and international boundaries.'[167] As McInnes and Lee have pointed out, implicit in this definition was a distinct call for action.[168] Central to this call for action – and a key feature of the report – was the implementation of the 2005 International Health Regulations (IHR), revised from the original IHR of 1969.

Unanimously agreed upon by the World Health Assembly on 23 May 2005, the revised IHR stayed true to their initial aim of controlling the international spread of disease while continuing to facilitate international trade and travel. However, the revised IHR expanded the focus of the original Regulations to incorporate a broader array of threats to include not just infectious diseases, but also 'those caused by the accidental or intentional release of pathogens, or chemical or radionuclear materials.'[169] This expanded scope was a consequence of the inapplicability of the original IHR to most emerging infectious diseases, made apparent with the outbreak and spread of SARS in 2002-2003. The revised IHR, then, not only took into account existing threats, but were also designed to apply to those threats that have yet to emerge. Moreover, they took into account threats to public health beyond infectious disease alone.[170] Threats to global public health security identified in the 2007 report, then, reflected the revised IHR and encompassed three categories of risk: epidemic-prone diseases; foodborne diseases; and events of either an accidental or deliberate origin that affect the natural environment and can have adverse health outcomes, such as chemical or radionuclear incidents or environmental disasters.[171] These threats derived not only from human behaviour, but also from the natural environment, impacting not only the

[167] World Health Organization. *A Safer Future: Global Public Health Security in the 21st Century*, World Health Report 2007 (Geneva, World Health Organization, 2007), p. ix.
[168] McInnes & Lee, *Global Health and International Relations*, p. 138.
[169] World Health Organization, *A Safer Future*, p. xv.
[170] Rodier, G., A. L. Greenspan, J. M. Hughes & D. L. Heymann. 'Global Public Health Security', *Emerging Infectious Diseases* 13(2007), p. 1448.
[171] World Health Organization, *A Safer Future*, pp. x-xii; McInnes & Lee, *Global Health and International Relations*, p. 138.

health of individuals and communities, but also carrying the potential to impact economic and political stability, trade and tourism, access to goods and services, and demographic stability.[172]

The primary means of addressing the array of threats advocated in the report was through the development of core public health capacities at national levels along with effective international coordination, such as through the implementation and operation of the IHR. Investment in public health infrastructure at national, regional and global levels was thereby argued as remaining at the core of global public health security and was an underlying theme permeating the report:

> A safer world…needs a global system based on strong national public health infrastructure and capacity, preparedness and risk reduction for specific health threats, and an effective international system for coordinated alert and response. Much progress has been made but this cannot be reproduced or sustained without major investment in national, regional and global public health infrastructure.[173]

Moreover, while the emphasis of the report was heavily placed on acute threats to health, the report maintained that a complete spectrum of public health security would also include a focus on endemic threats to health, the significance of primary health care and humanitarian action as a means of ensuring health security at the individual and community level not to go unnoticed.[174]

However, while the 2007 WHO report acknowledged the significance of issues such as 'maternal and child health, chronic disease, violence and mental health, among others' to

[172] World Health Organization, *A Safer Future*, p. 1.
[173] World Health Organization, *A Safer Future*, p. 55.
[174] World Health Organization, *A Safer Future*, p. 67.

public health security, the prominence given to risks to health covered by the IHR throughout the report served the function of narrowing down the focus of global public health security significantly.[175] On this point, Davies has argued that while on the one hand, the revised IHR signalled a recognition by the international community that protection against infectious diseases requires the cooperation and capacity of all states to monitor the emergence and circulation of disease, on the other hand, the WHO has only been marginally successful in its attempt to draw attention to the wider threat posed by communicable diseases and the particularly heavy burden they carry for those impoverished. The consequence, according to Davies, has been that only a select set of diseases can be considered to have been successfully propelled into the realm of 'high politics.'[176]

In a similar vein, Stephenson has argued that by problematizing circulation, 'the deployment of a notion of health security in global public health has made it harder to imagine and enact modes of global health that actually engage with the social lives of viruses or that tackle health inequities.'[177] Indeed, while the emphasis of the global public health approach to health security is on the global, the emphasis placed on the circulation of sources of vulnerability in a globalizing world makes the distinction between global public health security and health security as a manifestation of national or international security – that is, the emphasis placed on global health versus the critical functioning of the state and international system – increasingly difficult to ascertain. This is particularly the case given that both approaches have incorporated a concern with preparedness in accounting for those threats that have yet to emerge. The predominantly narrow approach to global public health security advocated in the 2007 WHO report, then, not only highlights the difficulty in

[175] World Health Organization, *A Safer Future*, p. 67.
[176] Davies, *Global Politics of Health*, pp. 153, 155-6.
[177] Stephenson, 'The Disappearing Act of Global Health Security', p. 98.

mobilizing health security broadly conceived, but also the fungibility of the term. In this respect, global public health security has not provided a clearly distinguishable operationalizable alternative to health security as articulated as a matter of national or international security with the effect that the two approaches have become increasingly intertwined.

Health security as a component of human security

As with the global public health approach to health security, health security as a component of human security is concerned with the broader structural conditions that determine health outcomes, both approaches adopting the same definition of health as provided by the WHO. However, whereas the global public health approach to health security is focused on ensuring the health of the population, the human security agenda is concerned with the security of the individual.

The United Nations Development Programme (UNDP)'s 1994 Human Development Report is largely credited as the first major document to advance a comprehensive notion of human security. Written in anticipation of the 1995 World Summit on Social Development in Copenhagen, the 1994 UNDP report set out to fundamentally shift the ontological basis of security from interstate conflict to that of the insecurities of people that arise from the worries associated with the everyday.[178] Rather than taking the state as the referent object of security, the concept of human security advocated in the report made the marked shift of placing the individual at the centre of security concerns. Underpinning the notion of human security were the dual concepts of freedom from want and freedom from fear,

[178] United Nations Development Programme. *Human Development Report 1994: New Dimensions of Human Security* (Oxford, Oxford University Press, 1994), p. 3.

encompassing safety from chronic threats such as hunger, disease, crime and repression, as well as the protection from sudden disruptions to patterns of daily life.[179] Human security is thus underpinned by what Caroline Thomas has identified as the 'values of protecting the vulnerable via the reduction of risk and holistic understanding of the constitution of vulnerability in a globalizing world.'[180] While the human security agenda shares similar concerns to that of the human rights and development agendas, as Sakiko Fukuda-Parr has argued, it differs from both by not only highlighting what has to be safeguarded – the integrity of the individual – but also accounting for risks of sudden change.[181]

While it did little to elucidate the link, the 1994 UNDP report was the first to articulate health security as a component part of human security, drawing particular attention to the interconnection between disease and poverty.[182] The 2003 United Nations Commission on Human Security report, *Human Security Now*, subsequently advanced a more detailed account of the concept of human security than that introduced in the 1994 UNDP report and expanded significantly on the notion of health security and its centrality to human security's advancement. Led by Sadako Ogata and Amartya Sen, the Commission on Human Security was established in 2001 by then-UN Secretary General, Kofi Annan, with the

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[179] United Nations Development Programme, *Human Development Report 1994*, p. 3.
[180] Thomas, C. 'Globalization and Human Security', in *Globalization, Development and Human Security*, edited by Anthony McGrew & Nana K. Poku (Cambridge, Polity Press, 2007), p. 108.
[181] Fukuda-Parr, 'New Threats to Human Security', p. 5.
[182] Interestingly, the 1994 UNDP report advanced a similar set of concerns with respect to the prioritization of health as those propounded by the Alma-Ata Declaration and the primary health care movement that emerged from it. The Alma-Ata Declaration was adopted at the International Conference on Primary Health Care in 1978 and located health firmly within the context of humanitarianism and health equity. See Davies, *Global Politics of Health*, pp. 35-6. The Declaration affirmed health as a fundamental human right and called for an acceptable level of health for all by the year 2000. This was achieved through the reallocation of resources from armaments and military conflicts to focus on economic and social development, paying particular attention to the provision of primary health care. See World Health Organization. *Declaration of Alma-Ata*, International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978. One can speculate as to the extent to which the Alma-Ata Declaration provided some of the conceptual groundwork for the evocation of health as a matter of human security in the 1994 UNDP Human Development Report. Both advocate a need for a shift in focus away from conventional security concerns toward alternative sources of insecurity associated with inequalities in health care provision, although the language of security is absent from the Declaration itself.

mandate to promote and develop the concept of human security as an operational tool for policy. Health was argued as both 'essential and instrumental' to human security's fruition, health defined in accordance with WHO's definition as 'not just the absence of disease, but as "a state of complete physical, mental and social well-being"', illness, disability and avoidable death constituting 'critical pervasive threats' to human security's realization.[183]

Identified on the basis of scale, urgency and reach as well as the effect of externalities, the Commission report listed three health challenges in particular that it identified as human security concerns: global infectious diseases; poverty related threats; and violence and crises.[184] Health security thus reflected human security's dual concern with the freedom from want and the freedom from fear, the former manifesting itself in the relationship between health and poverty, and the latter represented in the intersection of health with more traditional concerns of state stability and military security.[185]

A significant aspect of the Commission report was the simultaneous scaling down and scaling up of health security to focus not just on the responsibilities of individuals, communities and civil society organizations in promoting health security, but also on the state and international institutions and networks. While the referent object of security remained the individual, the Commission report advanced the argument that a strong system of global health governance focused on the promotion of the development of core public health infrastructure was fundamental to the provision of health security.[186] Key to health security, according to the Commission report, was thereby a focus on the

[183] Commission on Human Security. *Human Security Now* (New York, Commission on Human Security, 2003), p. 96. For the WHO's definition of health, see World Health Organization. *Constitution of the World Health Organization.*
[184] Commission on Human Security, *Human Security Now*, p. 97.
[185] McInnes & Lee, *Global Health and International Relations*, pp. 143-4.
[186] Commission on Human Security, *Human Security Now*, pp. 108-9; 92.

empowerment of individuals and communities, and protection through the prevention, monitoring and anticipation of health threats.[187] Human security was promoted as complementing state security in addition to enhancing the human rights and development agendas, the protection of the health of the public argued as constituting a global public good.[188] Rather than eschewing a role for the state in providing for health security, then, the state remained central to human security's realization.

The promotion of health security as a component of human security reached its height in the latter half of the 1990s and the first half of the 2000s, picked up by academics and practitioners alike as a strategic means of reorienting the focus of security away from the military apparatus of the state to the 'vital freedoms' of individuals.[189] How human security has been defined and utilized, however, has varied significantly amongst its proponents, dependent on who is engaged in its articulation and the motivation behind its use. Debates as to whether human security should be broadly or narrowly defined, or whether or not it should be considered complementary to state security or recognised as an alternative paradigm, have shaped and been shaped by the manner in which the concept has been put to use – that is, whether it has been used as a means of issue appropriation, a guiding policy principle, or as a critical tool.[190]

Within the field of health, a number of scholars have argued that human security broadly defined serves the conceptual function of expanding the notion of security to enable a consideration of both why and how particular health threats emerge, drawing

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[187] Commission on Human Security, *Human Security Now*, p. 102.
[188] Commission on Human Security, *Human Security Now*, pp. 102; 2.
[189] See Ogata, S. & J. Cels. 'Human Security – Protecting and Empowering the People', *Global Governance* 9 (2003), p. 274.
[190] Taylor Owen has identified four categories of use for human security: as a policy tool, as a means of issue appropriation, as a measurement tool, and as a critical tool. For a more in-depth description of all four, see Owen, 'Human Security: A Contested Concept', pp. 46-8.

attention to the complexity and multidimensional nature of contemporary health challenges and insecurities associated with them, as well as the roles actors and structures play in enhancing or diminishing insecurity.[191] Thus, from a normative perspective, human security has been advocated as serving the function of influencing the context in which actors enunciate and practice security.[192] On a practical level, some scholars argue that the added value of addressing particular health concerns as a matter of security rather than an issue of public health or development is significant in not only engaging a broad array of actors, but also galvanising the necessary political attention and resources needed to address insecurity.[193] As will be demonstrated below, however, the success of the human security agenda has been limited. The strength of the human security argument in mobilising action around issues of health is unclear and over time, human security broadly conceived has given way to a narrower focus on freedom from fear while the language in official documents has become increasingly intertwined with that of national security.

Within the United Nations (UN) system, UN Secretary-General Kofi Annan played an instrumental role in propelling the concept and application of human security forward, spearheading a series of General Assembly sessions aimed at addressing the human security implications of the HIV/AIDS epidemic and other poverty-induced insecurities, as well as promoting the continual conceptual development of human security as a practical framework for mobilising action. In his 2000 report, *We the Peoples*, presented at the United Nations Millennium Summit that same year, Annan called for the promotion of both

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[191] See, for example, Curley, M. & N. Thomas. 'Human Security and Public Health in Southeast Asia: the SARS outbreak', *Australian Journal of International Affairs* 58(2004), pp. 17-32; Elbe, 'HIV/AIDS: A Human Security Challenge for the 21st Century', p. 109; Maclean, 'Microbes, Mad Cows, and Militaries'; Thomas, 'Globalization and Human Security'; Thomas, C. 'Global Governance, Development and Human Security: Exploring the Links', *Third World Quarterly* 22(2001), pp. 159-175.
[192] McDonald, M. 'Human Security and the Construction of Security', *Global Society* 16(2002), p. 278.
[193] Altman, 'AIDS and Security', p. 422; Elbe, 'HIV/AIDS: A Human Security Challenge', p. 109.

freedom from want and freedom from fear as key operational principles in addressing the array of challenges facing the global community, the promotion of health and the combat of HIV/AIDS identified amongst the list of priority areas for action.[194]

Over the course of the following years, the promotion of health security was closely tied with efforts to address poverty. The Millennium Summit culminated in the UN General Assembly adoption of the UN Millennium Declaration, setting out a series of targets to be reached by 2015 to reduce poverty based on the principle of collective responsibility.[195] Widely known as the Millennium Development Goals (MDGs), these targets included a number of goals directed at health, including reducing child mortality, improving maternal health, and combating HIV/AIDS, malaria and other diseases. The Global Fund, a financing institution designed to combat HIV/AIDS, malaria and tuberculosis, was also established in this time period, following a UN General Assembly Special Session on HIV/AIDS in June 2001. The 2001 Special Session marked a milestone in HIV response, culminating in the *Declaration of Commitment on HIV/AIDS* that identified the epidemic as constituting 'a global emergency and one of most formidable challenges to human life and dignity.'[196]

By the turn of the millennium, the link between health and poverty was not only being promoted by the UN, including the WHO, but also by a number of other international actors, including the World Bank and the Group of Eight (G8). In January 2000, then-WHO Director-General, Gro Harlem Brundtland, established the Commission on Macroeconomics and Health, headed by Jeffry Sachs, as a means of 'chang[ing] the way the world thinks

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[194] Annan, K. *We the Peoples: The Role of the United Nations in the 21st Century* (New York, United Nations, 2000).
[195] United Nations General Assembly. *United Nations Millennium Declaration.* Resolution adopted by the General Assembly A/res/55/2, 8th plenary meeting, 8 September 2000.
[196] United Nations General Assembly. *Declaration of Commitment on HIV/AIDS*, United Nations General Assembly Special Session on HIV/AIDS 25-27 June 2001.

about health and development' by situating health 'at the heart of the development agenda.'[197] A key aspect of the Commission report was its promotion of health as a global public good, health propounded in the introductory remarks as not only integral to poverty reduction and economic growth, but also constituting a human right and a necessary component in the promotion of global security.[198] The World Bank's 1993 World Development Report also linked health care provision to poverty reduction strategies, while its 2000/2001 report explicitly linked poverty reduction and health to security:

> Vulnerability to external and largely uncontrollable events – illness, violence, economic shocks, bad weather, natural disasters – reinforces poor people's sense of ill-being, exacerbates their material poverty, and weakens their bargaining position. That is why enhancing security – by reducing the risk of such events as wars, disease, economic crises, and natural disasters – is key to reducing poverty. And so is reducing poor people's vulnerability to risks and putting in place mechanisms to help them cope with adverse shocks.[199]

Amongst the actions identified by the report as necessary in enhancing security was the need for cooperation between governments and the private sector in the development and distribution of vaccines for HIV/AIDS, tuberculosis and malaria.[200]

The extent to which the success gained in mobilising political support around the issues of health and poverty during this time period is attributable to the promotion of human security alone, however, is uncertain. While the UN Millennium Declaration makes

[197] Brundtland, G.H. Speech given at the Third Meeting of the Commission on Macroeconomics and Heath, Paris, 8 November 2000. WHO/DG/SP/196. Available from: http://www.who.int/macrohealth/background/paris08nov00.pdf [Accessed on 17 July 2013].
[198] World Health Organization. *Macroeconomic and Health: Investing in Health for Economic Development.* Report of the Commission on Macroeconomics and Health (Geneva, World Health Organization, 2001).
[199] World Bank. *The World Development Report 2000/2001: Attacking Poverty* (New York, Oxford University Press, 2001), p. 3.
[200] World Bank, *The World Development Report 2000/2001*, p. 12.

reference to human rights, development and international peace and security, for example, the Declaration does not mention human security explicitly. In fact, McInnes and Lee have argued that the advances made in addressing the nexus between health and poverty may be attributable to the coinciding of the health security agenda with a broader preoccupation with the 'war on poverty', the simultaneous focus on the links between poverty and health amongst development actors and proponents of human security reflective of what McInnes and Lee have suggested was a broader 'humanitarian *zeitgeist*.'[201] Over subsequent years, moreover, the promotion of human security as a framework for mobilising action has waned, gradually fading away from UN Secretary-General and high-level panel reports – at least explicitly – as well as from many of the UN organizations themselves.[202] Where human security has retained a degree of success in advancing health security, it has been in those instances where health security has primarily been promoted narrowly as freedom from fear.

This shift in emphasis is evidenced in the United Nations Secretary General's High-Level Panel on Threats, Challenges and Change's report, *A More Secure World*, published in 2004 – a mere year after the United Nations Commission on Human Security report, *Human Security Now*. Rather than promoting the concept of human security as developed in the 2003 Commission on Human Security report, the 2004 report focused on what it identified as 'comprehensive collective security.'[203] While the report maintained a broad conceptualization of threat to incorporate such issues as health, poverty and the environment, it shifted the referent object of security back to the state. Health threat in this

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[201] McInnes & Lee, *Global Health and International Relations*, p. 143.
[202] Martin, M. & T. Owen. 'The second generation of human security: lessons from the UN and EU experience', *International Affairs* 86(2010), p. 211.
[203] United Nations. *A More Secure World: Our shared responsibility*. Report of the Secretary-General's High Level Panel on Threats, Challenges and Change (United Nations, 2004).

context primarily concerned the threat posed by emerging infectious diseases, including the threat posed by biological agents, to the integrity of the state and to international security. This change in language suggests that human security had not been firmly embedded as an operating principle.

The opening remarks to the report thus called for closer attention to be paid to what it called 'biological security' by focusing on strengthening the global health system and public health capacity in the developing world in order to 'provide the basis for an effective global defence against bio-terrorism and overwhelming natural outbreaks of deadly infectious disease.'[204] Citing the 11 September 2001 terrorist attacks in the United States, the outbreak of SARS and pandemic influenza as examples of the threats faced in the contemporary security environment, the report made the case for comprehensive collective security on the basis of the transboundary nature of contemporary sources of insecurity and the mutual vulnerability created by them.[205]

The Oslo Ministerial Declaration of 20 March 2007 marked a similar shift in appeal to the security-health link. Born out of the Global Health and Foreign Policy Initiative, established in September 2006 and made up of the Ministers of Foreign Affairs from Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand, the Declaration sought to raise awareness as to the strategic significance of health to foreign policy and to provide an agenda for action in addressing threats to health on a global scale. The Declaration made a case for strengthening global health security on the basis of a shared global vulnerability to health threats. While the Declaration ultimately rooted health security in a human security approach to addressing vulnerability, arguing the case for understanding health as a

[204] United Nations, *A More Secure World*, p. viii.
[205] United Nations, *A More Secure World*, p. 15.

fundamental human right as well as a prerequisite for development and poverty reduction, the Declaration explicitly evoked national security sensibilities in its promotion of global health collaboration. The Declaration stated:

> While national security focuses on the defence of the state from external attack, national health security relates to defence against internal and external public health risks and threats. These are risks and threats that by their very nature do not respect borders, as people, animals and goods travel around the world faster than ever before. The responsibility of protecting against health threats must therefore be based on the shared commitment and the capacity of countries. Global health security is only as strong as its weakest link.[206]

The appeal to both national security and human security in this instance highlights the fungibility of health security as a concept, the blurred distinction between human security and national security seeming to undermine the promotion of human security as an alternative actionable paradigm. In fact, Elbe has criticized the concept of human security precisely on this point, arguing that human security has not been able to effectively challenge the traditional approach to national security, its advocates often being drawn back into the realm of national security to achieve their aims. For Elbe, this raises the question as to whether the introduction of a new concept of security alone is enough to alter international security's architecture.[207]

Indeed, while conceptually human security has provided a valuable means by which to begin to consider a wider array of sources of insecurity, their origins, and the structures

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[206] Ministers of Foreign Affairs of Brazil, France, Indonesia, Norway, Senegal, South Africa & Thailand. 'Oslo Ministerial Declaration – global health: a pressing foreign policy issue of our time', *The Lancet* 369(2007), pp. 1373-4.

[207] Elbe, 'HIV/AIDS: A Human Security Challenge', p. 111.

and actors that facilitate them, in practice the human security paradigm has not been successful in mobilising action beyond issue-specific concerns. The utility of human security as a conceptual framework has ultimately failed to gain salience within the international policy community as well as with much of IR's engagement with health and security. This may in part be attributable to the broad conceptualization of security encompassed by the human security agenda, the paradigm having been met with criticism for being too imprecise and all-encompassing to provide sufficient guidance for the prioritization of threat and for the identification of means of response.[208]

However, McInnes and Lee have suggested that human security's inability to effectively challenge national security as a dominant paradigm may also in large part 'be due to the manner in which Western governments have been able to construct terrorism both as the dominant security concern after 9/11 and as a national security problem', indicative, according to McInnes and Lee, of the 'continued power of states, especially Western states, to construct security narratives…and the inability of states to deal with new risks.'[209] In fact, Harley Feldbaum, Kelley Lee and Preeti Patel have argued that it was not until after the 11 September terrorist attacks in the United States in 2001 that the Western security community significantly began to engage with HIV/AIDS in sub-Saharan Africa, the perceived linkage between failed states as harbourers of terrorists and the potential role of HIV/AIDS in fostering state failure making the health security of populations in other regions of the world a central interest to the security of the West.[210]

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[208] See, for example, Alkire, S. 'Concepts of Human Security' in *Human Insecurity in a Global World*, edited by L. Chen, S. Fukuda-Parr & E. Seidensticker (Cambridge, MA & London, Harvard University Press, 2003), p. 22; Enemark, *Disease and Security,* pp. 18-19; Paris, R. 'Human Security: Paradigm Shift or Hot Air?', *International Security* 26(2001), pp. 87-102.
[209] McInnes & Lee, *Global Health and International Relations*, p. 145.
[210] Feldbaum, Lee & Patel, 'The National Security Implications of HIV/AIDS', p. 0776.

Arguably the series of outbreak events that have occurred following the 11 September 2001 attacks have also contributed to the reinforcement of this dominant security narrative. The anthrax attacks of 2001 and the outbreak and spread of SARS in 2002-2003 drew attention to the proximate vulnerability of even the most economically developed states to disease emergence, contributing to the reconfiguration of notions of insecurity at the national level. The heightened attention given to the threat of pandemic influenza following the resurgence of the H5N1 avian influenza virus in 2004-2005 reinforced this identified vulnerability by highlighting the ever-present emergent potential of a highly virulent biological agent. The combination of these three factors – the lack of conceptual coherence on the part of human security, the continued presence of state interest in shaping international engagements with health, and the impact of crisis events in reorienting the focus of health security – has contributed to the inability of human security to effectively compete with the (inter)national security paradigm as the primary means of engaging with health security internationally.

The broadening of the security agenda following the end of the Cold War, then, and the evolution of the various approaches to the security-health nexus that have emerged from it, has been significantly shaped by the emerging infectious diseases narrative that gained prominence in the 1990s and that has since been reinforced by a series of outbreak events. The experiences with the anthrax attacks in 2001 following the 11 September terrorist attacks in the United States, the outbreak and spread of SARS in 2002-2003 and the resurgence of the H5N1 avian influenza virus in 2004-2005, all served to reinforce the growing preoccupation with the emergence and circulation of infectious diseases within this time period, reorienting the focus of security away from prevention alone to focus

increasingly on preparedness. The result has been a predominantly narrow engagement with the security-health nexus, health security primarily concerned with the management of a limited set of diseases and the risk they carry for the continued critical functioning of the state and the international system. This narrow focus has not only been characteristic of the national or international security approach to health security, but has also been reflected in the global public health and human security approaches to health security, with the consequence that the distinction between the three approaches has become increasingly blurred over time.

The predominance of the national or international security approach to health security in contemporary engagements with the security-health nexus, along with the overlaps in focus amongst the three approaches to health security despite their differing agendas, is significant for the purposes of this thesis on two counts: First, it brings to the fore the strategic or pragmatic use of language in engagements with challenges to global health. This strategic use of language is not only evidenced in the instances of the global public health and human security approaches to health security, where the language of security is employed for the specific means of redirecting attention and mobilising action around a specific set of concerns, but also in the instance of health security understood as a manifestation of national or international security. In the latter case, the language of security has held particular salience despite the absence of robust empirical evidence supporting claims to the link.

Second, given this strategic or pragmatic use of language, the rise of health security internationally raises the question as to how (if at all) the language of security is being deployed in the EU context to address health challenges and for what purposes. On this

point, this thesis maintains that as in the international context, the evocation of the link between health and security at the level of the EU has been used for specific means. In the case of the EU, the emergence of a health security agenda has provided a means for the EU to reinforce a distinct role and identity for itself as an actor in the domain of public health and as a manager of health threats within the European space. The rise of health security within the EU context, then, has been linked to the EU integration project and has been closely tied to developments internationally. The domain of public health has thus emerged as an additional area where the EU's evolving role as a security actor can be documented.

The institutional context: The evolution of the EU's role in public health

It is within the context described above that the EU's role in public health has emerged. This section argues that three factors in particular have influenced the development of EU-level competences in the domain of public health: the growing international preoccupation with the security risks associated with the microbial world post-Cold War, reinforced by a number of outbreak events; the presence and influence of a number of international bodies engaged with various aspects of health security provision; and the interrelation between communicable disease management and the EU integration project. The chapter argues that the growing preoccupation with health security at the level of the EU over the course of the past 20 years has reflected the narrow engagement with health security that has predominated internationally and has primarily concerned ensuring the economic and political integrity of the Union as a whole alongside the protection of EU citizens from the threat of infectious diseases.

Indeed, in keeping with international engagements with the security-health nexus to date, a central theme underpinning the EU's evolving role as health security provider has been the collective vulnerability to the global circulation of disease. The recognised speed with which diseases travel across borders, facilitated on the one hand, by processes of globalization and on the other hand, by the open borders within the Union, along with a series of health crises, has prompted increased coordination in providing for public health protection at EU level. These developments have been closely tied not only to the development of the European Common Market, but also to the shift in the EU's role as primarily an economic entity to an increasingly political one. Marco Liverani and Richard Coker have asserted that the emphasis placed on the notion of 'European citizen' has given public health more prominence in the Union, while the territorial emphasis placed on understandings of 'European Community', expressed in terms of a shift in emphasis from internal security to the importance of monitoring the flow of people and goods between internal and external spaces of the Union, has reflected a growing concern with border control and security post-Cold War.[211] This latter point has resulted in a preoccupation with ensuring the continued circulation of people and items considered good for the Union, while keeping undesirable things, such as communicable diseases, at bay.[212] The EU has thus emerged as an additional site where the roles and responsibilities of actors in managing the global circulation of disease are being played out.

While the EU has gained an increased role in providing for public health protection within the Union over time, this role has not grown in isolation of broader international engagements with health security. Rather, EU-level developments have echoed

[211] Liverani & Coker, 'Protecting Europe from Diseases', pp. 921-3.
[212] Liverani & Coker, 'Protecting Europe from Diseases', pp. 922-3.

developments internationally and the EU's role in public health has been tempered by the occasionally overlapping roles of international bodies such as the WHO and the networks in which the EU collaborates, including the Global Health Security Initiative (GHSI) and the WHO-run Global Outbreak and Response Network (GOARN).[213] The role of the WHO in managing communicable disease is of particular mention in this context given the role that it plays in standardizing outbreak response strategies globally through the IHR. While the EU is itself not party to the IHR, all EU Member States are. Moreover, Article 57 of the IHR stipulates that States Parties belonging to a regional economic integration organization need to abide by the common rules in force such that if the WHO were to recommend restrictions on trade and travel, the EU would have to respond collectively, at the impetus of the Commission.[214] Decisions taken by the WHO, then, not only have the capacity to influence securitizing dynamics at the level of the EU, but also potentially the form of response.

Other regional organizations, such as the Organization for Economic Co-operation and Development (OECD) and the Council of Europe (CoE) also have a history of involvement in health issues.[215] As such, the EU has entered a space already marked by the activities of a number of international bodies that overlap in membership with the Union. Thus, while the focus of this thesis is on the specific dynamics amongst the EU institutions themselves in the process of securitizing pandemic influenza, broader contextual developments play an important role in this process. As Sébastien Guigner has pointed out,

[213] Brattberg & Rhinard, 'Multilevel Governance and Complex Threats', p. 3.

[214] World Health Organization. *International Health Regulations (2005)*, 2nd edition (Geneva, World Health Organization, 2005); McKee, M., T. Hervey & A. Gilmore. 'Public health policies', in *Health Systems Governance in Europe: The Role of European Union Law and Policy*, edited by Elias Mossialos, Govin Permanand, Rita Baeten & Tamara Hervey (Cambridge: Cambridge University Press, 2010), p. 248.

[215] Guigner, S. 'The EU's role(s) in European public health: the interdependence of roles within a saturated space of international organizations', in *The European Union's Role in International Politics: Concepts and analysis*, edited by Ole Elgström & Michael Smith (London & New York: Routledge, 2006), p. 225.

given the crowded field in which the EU is operating, the Commission, as the agent of the EU, has had to demonstrate the utility of the Union's engagement in public health.[216] One can expect, then, that any securitizing moves coming from the Commission will be based in part on an argument promoting the unique role and position of the Union in this domain.[217] Indeed, in this respect, the promotion of health security at EU level can be seen as a strategic means of the European Commission to advocate a distinct role for itself as a health security provider. Given the close relationship between the EU's evolving role as a manager of cross-border health threats and the rise of health security internationally, moreover, it is clear that pandemic influenza has not been institutionalized as a security threat prior to EU engagement in the field of public health.

The legal basis for Community action in the field of public health was first established with the entering into force of the Maastricht Treaty (also known as the Treaty of the European Union (TEU)) in 1993. Paragraph 1 of Article 129 stipulated that the Community was to 'contribute towards ensuring a high level of human health protection by encouraging cooperation between Member States and, if necessary, lending support to their action,' thereby establishing a distinct role for the EU in public health protection.[218] The entering into force of the TEU provided a means of formalizing the number of cooperative arrangements that had developed amongst Member State health ministers and the Commission in response to health crises in previous years, such as the 'Europe against

[216] Guigner, S. 'The EU's role(s) in European public health', p. 229.
[217] On this point, Sebastiaan Princen has argued: 'In bringing issues to the EU agenda, framing not only involves the nature of problems and solutions, but also the appropriateness of the EU as a level of government. Actors have to argue not only that certain substantive aspects of an issue are more important than others, but also that European action is needed to address them. In short, they have to construct a story about why the issue is European in scope.' Princen, S. *Agenda-setting in the European Union* (Houndmills, Basingstoke & New York, Palgrave Macmillan, 2009), pp. 39-40.
[218] *Treaty of the European Union*. OJ C 191, 29 July 1992; Cucic, S. 'European Union health policy and its implications for national convergence', *International Journal for Quality in Health Care* 12(2000), p. 219.

Cancer' programme in 1987 following the Chernobyl nuclear power station explosion and the programme against AIDS in 1991.

Both of these programmes were in response to events that had underscored the need for Community collaboration. While the events in Chernobyl had highlighted the need for cooperation on research and data collection on transborder risks to health, the AIDS epidemic in Central and Eastern Europe, according to Monika Steffen, contributed to the development of larger EU public health policy, coinciding as it did with EU enlargement into that region and prompting the coordination of communicable disease control in the Union.[219] The TEU thus enabled the formal organization of these activities by introducing what Strasimir Cucic has identified as three important changes to the EU's engagement with public health: (1) a clearly delineated authority for the EU in health protection through a dedicated article; (2) the basis for the creation of a framework for action focused on public health and prevention of disease; and (3) a review of all EU policies to account for possible adverse effects on health or the undermining of health promotion.[220]

The Amsterdam Treaty, signed in October 1997 and entering into force in May 1999, further engrained the role of the EU in public health protection. New public health risks – in particular, the Bovine Spongiform Encephalopathy (BSE) or 'mad cow' crises in the early to mid-1990s – underscored the need for the reorganization of public health protection arrangements at Union level.[221] This included the creation of a new Directorate-General (DG) for Health and Consumer Affairs (SANCO) in 1999, later to become the DG for Health and Consumer Protection in 2008 and now referred to as DG for Health and Consumers. This

[219] Steffen, 'The Europeanization of Public Health', p. 1063.
[220] Cucic, 'European Union health policy and its implications for national convergence,' p. 219.
[221] Steffen, 'The Europeanization of public health', p. 1069.

marked, according to Guigner, ‘a decisive turning point in that it allowed health matters to gain a material and symbolic visibility within the Commission, thereby establishing that health was one of the Union’s objectives.’[222] Reflecting the need for a reinforced approach to public health within the Union, Article 152 of the Amsterdam Treaty stipulated that the Community was not just to contribute towards, but to *ensure* ‘a high level of human health protection’ by integrating health protection into all Community policies and activities. Paragraph 1 of Article 152 read as follows:

> 1. A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities.
>
>   Community action, which shall complement national policies, shall be directed towards improving public health, preventing human illness and diseases, and obviating sources of danger to human health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education.
>
>   The Community shall complement the Member States’ action in reducing drugs-related health damage, including information and prevention.[223]

The Amsterdam Treaty thus extended the powers of the EU institutions in providing for public health protection, providing further organizational coherence to EU institutional engagement in the field of public health.[224]

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[222] Guigner, *Health: A vital issue for Europe*, pp. 36-7. Guigner has argued, however, that the structure of the new DG was not ideal, being perceived ‘more as a “Consumer Protection DG” rather than a “Health DG.”’ Guigner, ‘Health: A vital issue for Europe’, p. 37.

[223] *Treaty establishing the European Community (Nice consolidated version) – Part Three: Community policies – Title XIII: Public Health – Article 152*. OJ C 325, 24/12/2002 P. 0100-0101.

[224] Hervey, T. & J. V. McHale. *Health Law and the European Union* (Cambridge, Cambridge University Press, 2004), p. 81.

The Lisbon Treaty, signed on 13 December 2007 and entering into force on 1 December 2009, further elaborated upon the EU's health protection role. Paragraph 1 of Article 168 retained the thrust of Article 152 but expanded upon the activities covered by the Community by adding 'monitoring, early warning and combating serious cross-border threats to health' to the list of Union actions. From the period spanning the entry into force of the TEU in 1993 to the entry into force of the Lisbon Treaty in 2009, then, the Community's role in health protection had become increasingly enhanced, Member State governments entrusting the Commission with more authority to coordinate responses to health threats.[225] As will be demonstrated below, these developments have not only grown out of experiences with health crises within the Union, but are also a reflection of the rising concern with communicable disease emergence that has been documented internationally.

The legal basis for Community action provided by the successive EU treaties paved the way for the development of a series of frameworks for action in public health over subsequent years. The first framework for action was introduced in 1993 in light of the new community competences gained by the entering into force of the Maastricht Treaty. The framework was structured around five major health-related challenges identified as facing Member States at the time: ageing populations; increasing population mobility; changes in the environment and work setting; rising expectations concerning the delivery of public health services; and socio-economic problems, particularly social exclusion.[226] Under the framework, eight action programmes were created, addressing cancer, AIDS, drug dependence, health promotion, health monitoring, rare diseases, injuries, and pollution-

[225] Brattburg & Rhinard, 'Multilevel Governance and Complex Threats', p. 2.
[226] Commission of the European Communities. *Commission communication on the framework for action in public health*. COM(93) 557 final. Brussels, 24 November 1993, p. 1c.

related diseases respectively.[227] These action programmes primarily reflected issues internal to the European Union at the time and marked the beginnings of the formalization EU public health policy.

However, with the strengthened role of the Community in health protection brought on with the signing of the Amsterdam Treaty in 1997, the first framework for action was renegotiated and a new framework introduced with three new policy strains: information exchange; rapid reaction to threats to health; and disease prevention and health promotion.[228] The grounds for this new framework were argued by the Commission Communication introducing the framework on the basis of the presence of a number of new health challenges that warranted a new Community policy orientation. These challenges included: levels of premature mortality; the emergence of new risks to health, such as a new variant Creutzfeldt-Jacob Disease (CJD), avian influenza, Ebola haemorrhagic fever and AIDS; the resurgence of old diseases resistant to antibiotics, such as tuberculosis; the continued variations and inequalities in the health status of populations; and health issues related to an ageing population.[229] While this list encompassed some of the issues raised in the first framework for action, significantly, the concern raised about emerging and resurging infectious diseases also reflected developments on the international scene, the references to avian influenza, Ebola, HIV/AIDS and tuberculosis in particular not only referring to

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[227] Commission of the European Communities. *Communication from the Commission to the Council, the European Parliament, the Economic and Social Committee, and the Committee of the Regions on the development of public health policy in the European Community*. COM(98) 230 final. Brussels, 15.04.1998, p. 8.

[228] Commission of the European Communities, *Communication on the development of public health policy in the European Community*. This new framework was adopted in a Council Resolution on 2 June 1994, which invited the Commission to both produce proposals for action in the priority areas identified in the Resolution and establish a consultative body to advise the Commission in the formulation of health-related proposals. Council of the European Union. *Council Resolution of 2 June 1994 on the framework for Community action in the field of public health*. OJ C 165, 17/06/1994, pp. 0001-0002.

[229] Commission of the European Communities. *Communication from the Commission on the development of public health policy in the European Community*, p. 10.

developments within the European space, but also to outbreaks in other areas of the world that had galvanised international attention in the 1990s.

Indeed, in May 1995, the World Health Assembly passed two resolutions that had direct bearing on international efforts to control communicable diseases - WHA48.13 on new, emerging and re-emerging infectious diseases and WHA48.7 on the revision and updating of the International Health Regulations (IHR). Both resolutions urged governments to take the threat of communicable diseases seriously, outbreaks of disease in India, Zaire and the United States in 1994 and 1995 having drawn attention to the need to address communicable disease emergence and resurgence, particularly in light of the heightened risk of international spread due to the growth of commercial air transport.[230] Resolution WHA48.7 both 'acknowledged the strengthening of epidemiological surveillance and disease control activities at national level as the main defence against the international spread of infectious diseases' and requested the Director-General to begin the preparation of the revision of the International Health Regulations.[231] In 1997 the WHO also began to formalize a set of collaborative networks between government laboratories, WHO regional offices, non-governmental organizations and specialized agencies in the UN as a means of enhancing global disease surveillance, leading to the creation of the global outbreak alert and response network (GOARN) in April 2000.[232] EU-level activities thus did not develop independently of broader international activities aimed at addressing communicable disease emergence, but rather were also informed by them.

[230] Kamradt-Scott, A. *Managing Global Health Security* (Ph.D. Thesis, University of Wales, Aberystwyth, 2008), pp. 141-2; World Health Organization. *Revision of the International Health Regulations: Report by the Secretariat*. A56/25, 24 March 2003.
[231] World Health Organization, *Revision of the International Health Regulations*.
[232] Kamradt-Scott, *Managing Global Health Security*, p. 144.

A central component of the strand of action focused on rapid reaction to threats to health under the new framework for action, then, was the creation of a Community surveillance and early warning and reaction capability, coordinated at Community level as a means of building a capability to deal rapidly with future disease outbreaks.[233] In keeping with this objective, on 24 September 1998, the Parliament and the Council adopted Decision 2119/98/EC legally establishing a network for surveillance and control of communicable diseases in the Community. Surveillance covered threats to health considered to have the capacity to evolve rapidly, including communicable diseases, pollution-related health risks, and the safety of biological products. The objectives of epidemiological surveillance were to ascertain the incidence and characteristics of a particular infectious disease, to study its pattern of spread in order to be able to take appropriate counter-measures, to detect disease clusters or epidemics through a system of warning indicators in order to be able to take measures to break the specific transmission chain, and to identify the risk factors for

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[233] Commission of the European Communities, *Communication on the development of public health policy in the European Community*, p. 14. Interest in establishing communicable disease surveillance networks in the Community had been expressed prior to the renegotiation of the 1993-1998 framework for action in public health. On 13 November 1992, the Health Council adopted a resolution inviting the Commission to report on existing arrangements in place, both between Member States and by the World Health Organization, for the surveillance of communicable diseases, including food-borne diseases, and to put forward a proposal for improvements in the existing system. See Council of the European Union. *Resolution of the Council and the Ministers for Health of the Member States Meeting Within the Council of 13 November 1992 on the monitoring and surveillance of communicable diseases*. OJ 92/C 326/01 of 11.12.1992. Similarly, in a resolution on health policy post-Maastricht adopted in 1993, the Parliament invited the Commission to establish a network to provide working definitions of notifiable diseases as well as to collect and disseminate data on notifiable diseases to Member States. See European Parliament. *Resolution on public health policy after Maastricht*. OJ C329/375, 6.12.1993. The Council also adopted Conclusions on 13 December 1993 in which it requested the Commission to develop a proposal for the establishment of a Community epidemiological network. Council of the European Union. *Council Conclusions of 13 December 1993 on setting up an epidemiological network in the Community*. OJ 94/C 15/04 of 18.1.94. See Commission of the European Communities. *Commission Communication concerning communicable disease surveillance networks in the European Community*. COM(96) 78 final. Brussels, 07.03.1996, pp.2-3. The Commission, responding to previous requests made by the Parliament and by the Council, put forward a proposal for the establishment of a network for the epidemiological surveillance and control of communicable diseases in the Community to the Parliament and the Council for a Decision in 1996. The proposal was subsequently amended and the amended proposal was submitted by the Commission to the Council and the Parliament on 4 February 1997 See Commission of the European Communities. *Amended proposal for a European Parliament and Council Decision creating a network for the epidemiological surveillance and control of communicable diseases in the European Community*. OJ C 103/11, 2.4.1997. On 24 September 1998, the Parliament and the Council adopted Decision 2119/98/EC legally establishing the network.

contracting a communicable infection in order to take the preventive measures and recommendations.[234] A committee made up of Member State representatives and chaired by the Commission, often referred to as the 'Network Committee', was created in order to assist the operation of the network.[235]

The significance of the establishment of the network for surveillance and control of communicable diseases for the evolving role of the EU in providing for health security is two-fold: First, although not justified on the basis of a security logic, the creation of the network once again reflected a growing concern with microbial emergence internationally following a series of outbreak events in the 1990s. The Commission Communication addressing the creation of a network for epidemiological surveillance and control in the Community referenced the outbreak of Plague in India in 1994 and the appearance of the Ebola virus in Zaire in 1995 as events that drew attention to the need to act against infectious diseases, justifying the need for epidemiological surveillance at Community level on the following grounds:

> It is a long-established fact that infectious diseases caused by various microbial agents tend to spread through populations irrespective of borders, essentially as a result of the movements of people and, to a lesser extent, the movement of goods and the consumption of water and foodstuffs. Additional factors include climatic change (global warming), increased resistance to antibiotics, the immunological

[234] Commission of the European Communities, *Commission Communication concerning communicable disease surveillance networks*, p. 4.

[235] Articles 7 and 3 of Decision 2119/98/EC outlined the role and responsibilities of the committee, which included advising the Commission on: measures to be taken as they pertained to the communicable diseases to be progressively covered under the network; the criteria for the selection of these diseases; case definitions; the nature and type of data and information to be collected; epidemiological and microbiological surveillance methods; protective measures to be taken, particularly in emergency situations; information, recommendations and good practice guidelines for the public; and means by which data is to be disseminated and analysed at Community level. See *Decision No 2119/98/EC of the European Parliament and of the Council of 24 September 1998 setting up a network for the epidemiological surveillance and control of communicable diseases in the Community.* OJ L 268, 03/10/1998 P. 0001-0007.

> status of individuals, and living conditions (socio-economic problems). The more that people travel about, and the further they travel, the greater the risks of these diseases spreading in the form of epidemics in unprotected populations and, as a corollary, the greater the health risks to populations. From Asian flu and cholera, to the HIV virus responsible for AIDS, examples abound both in history and in the present day. The agents responsible for communicable infectious diseases do not respect geographical frontiers. And despite substantial progress in the field of public health protection, the exposure of populations to the risk of contracting these diseases is increasing all the time.[236]

The argument presented for the establishment of the network for surveillance and control of communicable diseases thus echoed the underlying themes of collective vulnerability to the global circulation of infectious diseases that underpin the three approaches to health security outlined previously. Although the Commission Communication did not frame communicable disease as a threat to security per se, it did express an awareness of an increasing vulnerability to communicable disease outbreaks. Epidemiological surveillance was thereby argued as essential in providing as accurate an understanding of an epidemiological situation as possible so as to ensure that the necessary measures needed to prevent the appearance or progress of an infectious disease are taken.

Second, Decision 2119/98/EC establishing the network for surveillance and control of communicable diseases provided the basis for the further development of the Community's surveillance and response system in years to come, including providing the framework for the European Influenza Surveillance Scheme (EISS), funded by the Commission since November 1999 and established to facilitate rapid exchange and provide early detection of influenza infections in Europe. Thus, on 22 December 1999, the Commission passed Decision 2000/57/EC establishing an early warning and response system

[236] Commission of the European Communities, *Commission Communication concerning communicable disease surveillance networks in the European Community*, p. 2.

for the prevention and control of communicable diseases under Decision 2119/98/EC, the purpose of which was to respond to 'those events...or indications for such events which, by themselves or in association with other similar events, are or have the potential to become public health threats.'[237] Annex 1 of Decision 2000/57/EC described those events to be reported within the early warning and response system as follows:

1. Outbreaks of communicable diseases extending to more than one Member State of the Community.
2. Spatial or temporal clustering of cases of disease of a similar type, if pathogenic agents are a possible cause and there is a risk of propagation between Member States within the Community.
3. Spatial or temporal clustering of cases of diseases of a similar type outside the Community, if pathogenic agents are a possible cause and there is a risk of propagation to the Community.
4. The appearance or resurgence of a communicable disease or an infectious agent which may require timely, coordinated Community action to contain it.[238]

On the same date the Commission also passed Decision 2002/253/EC expanding the list of communicable diseases to be covered under Decision 2119/98/EC to include, amongst other diseases and special health issues, influenza.

In keeping with these developments, under the second framework for action on public health, the first Community action programme was established, adopted on 23 September 2002 and spanning the period from 2003 to 2008. The programme built on the activities of the first 1993-1998 framework on public health as well as on the network for

[237] *Commission Decision of 22 December 1999 on the early warning and response system for the prevention and control of communicable diseases under Decision No 2119/98/EC of the European Parliament and of the Council*. OJ L 21, 26.1.2000, p. 32.
[238] *Commission Decision of 22 December 1999 on the early warning and response system*.

disease surveillance and control, and had the dual aim of protecting human health and improving public health.[239] The programme was made up of three strands: 'improving information for the development of public health, reacting rapidly to health threats and tackling health determinants through health promotion and disease prevention.'[240] A second programme for action in the field of health and consumer protection was subsequently adopted in 2007, spanning the period between 2008 and 2013.[241] The 2008-2013 programme sought to reinforce the three strands of the previous programme focused on information, threats and determinants, but also introduced three new strands: response to threats; disease prevention; and cooperation between health systems.[242]

In line with previous assertions, the Decision adopted by the Parliament and the Council establishing the second programme on public health reasserted the need for further Community action based on the existence of '[a] number of serious cross-border health threats with possible worldwide dimension' that necessitated the Community to 'treat serious cross-border health threats as a matter of priority.'[243] In addition to the burden to health posed by non-communicable diseases, the Decision referenced HIV/AIDS, influenza,

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[239] *Decision No 1786/2002/EC of the European Parliament and of the Council of 23 September 2002 adopting a programme of Community action in the field of public health (2003-2008).* OJ L 271/1, 9.10.2002.
[240] *Decision No 1786/2002/EC of the European Parliament and of the Council adopting a programme of Community action in the field of public health (2003-2008).*
[241] See *Decision No 1350/2007/EC of the European Parliament and of the Council of 23 October 2007 establishing a second programme of Community action in the field of health (2008-13)*. OJ L 301.3, 20.11.2007. A legislative proposal for a new health for growth programme (2014-2020) was put forward by the Commission in November 2011 and is currently being negotiated with the Parliament and the Council.
[242] Commission of the European Communities. *Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions. Healthier, safer, more confident citizens: a Health and Consumer Protection Strategy*. COM(2005) 115 final. Brussels, 6.4.2005, pp. 5-6.
[243] *Decision No 1350/2007/EC establishing a second programme of Community action in the field of health (2008-13).*

tuberculosis and malaria as 'threat[s] to the health of all people in Europe', along with the threat of microbial resistance.[244]

The need for Community-level action in confronting health threats was reiterated in a Commission White Paper introducing the new health programme. The White Paper argued that cooperation at Community level was 'indispensible' in tackling 'major health threats and issues with cross-border or international impact, such as pandemics and bioterrorism, as well as those relating to free movement of goods, services and people,' linking the Community's role in enhancing the capacity to respond to health threats to 'the Commission's overall strategic objective of Security.'[245] Indeed, by this point in time, the EU had witnessed and experienced the effects of the 2001 anthrax attacks in the United States, the outbreak and spread of SARS in 2002-2003, and the resurgence and spread of the H5N1 avian influenza virus in 2004-2005. Protecting citizens from threats to health was one of three strategic objectives identified in the White Paper, '[i]mproving security and protecting citizens against health threats' argued as having 'always been at the heart of Community health policy.'[246] The simultaneous reference to the protection of European citizens and to the free movement of goods and services is of note as it draws on familiar elements of arguments for health security promoted internationally, but deployed in the particular regional context of the EU. The emphasis placed on circulation is of particular note in this regard as the open borders within the EU are crucial to arguments for additional EU

[244] *Decision No 1350/2007/EC establishing a second programme of Community action in the field of health (2008-13).*
[245] Commission of the European Communities. *White Paper. Together for Health: A Strategic Approach for the EU 2008-2013.* COM(2007) 630 final. Brussels, 23.10.2007, pp. 2-3.
[246] Commission of the European Communities, *White Paper. Together for Health*, p. 8. The other two strategic objectives were to foster good health amongst the European population and to support health systems and new technologies.

competences and for overriding the principle of subsidiarity in managing cross-border health threats in the Union.

The increased Community competences in the field of public health granted by successive EU treaties have provided the backbone for the development of Community activities aimed at addressing the challenges posed by the microbial world and, for the purposes of this thesis, the backdrop to the process of securitizing pandemic influenza at the level of the EU. The evolution of these competences and the creation of the frameworks for action enabled by them have grown out a series of crisis events and have coincided with a growing preoccupation with health security internationally. The rising international concern with the emergence and circulation of communicable diseases from the 1990s onward has thus also been reflected at EU level, King's 'emerging diseases worldview' featuring in Commission Communications as justification for the need for further cooperation in addressing disease emergence and circulation in the EU context. The 2001 anthrax attacks, the outbreak and spread of SARS in 2002-2003 and the experiences with the resurgence of H5N1 in 2004-2005 – three outbreak events that will be examined in more detail in the next chapter of this thesis – have also served to reorient the focus of health security provision both internationally and at the level of the EU.

Within the EU, the gradual convergence of the realms of health and security has predominantly reflected a narrow approach to health security provision. Focus has primarily fallen on protecting the European space from disease circulation. The rise of a concern with health security at the level of the EU has thus been closely tied to the consolidation of the EU economic and political space, and – as will be demonstrated in more detail in subsequent chapters – has served the strategic purpose of asserting a distinct role for the EU as a

manager of health threats within the Union. The field of public health is therefore another area where the role of the EU as a security actor is emerging. The parallels between the emerging role of the EU in the domain of public health and the rise of health security internationally, moreover, suggests that pandemic influenza was not established as a security threat prior to the EU's entry into the field of public health, but rather that the process of securitizing pandemic influenza at Union level has been an integral part of the evolving role of the EU in this domain.

Conclusion

This chapter has introduced the contextual backdrop that has informed the process of securitizing pandemic influenza at the level of the EU. The chapter has argued that over the course of the past 20 years the link between health and security has taken on renewed significance, borne out of the recognition of a broader array of sources of insecurity post-Cold War and out of processes of globalization that have reinforced a sense of growing interconnectivity and mutual vulnerability to the challenges posed by the microbial world. Throughout this time period, three broad approaches to the security-health link have been promoted: health security as a matter of human security; health security as understood from the standpoint of global public health; and health security as a manifestation of national or international security. While each approach differs slightly with respect to the rationale behind health security's evocation, all three approaches share a concern with vulnerability and the need for transnational collaboration in preventing or at least mitigating health insecurities.

The chapter has argued, however, that it is the manifestation of health security as a matter of national or international security that has dominated international engagements with the security-health nexus to date. This has been attributed to three factors: First, a series of outbreak events have reoriented the focus of health security to rest predominantly on the threat of the emergence of highly virulent diseases to the economic and political stability of the state. This has not only been demonstrated by the prevalence of the 'emerging diseases worldview' in shaping international approaches to health security, but also by the impact that such outbreak events as the 2001 anthrax attacks, the 2002-2003 experience with SARS and the resurgence of the avian influenza H5N1 virus in 2004-2005 have had on reorienting engagements with the security-health link. Second, state interest has continued to hold prevalence in shaping international engagements with health. This has been indicated by the predominantly narrow focus of the health security agenda and by the appeal to national security sensibilities in promoting the aims of human security or global public health. Third, the human security and global public health approaches to health security have not been able to provide distinct operationalizable alternatives to the health and (inter)national security paradigm. As has been demonstrated, the human security and global public health approaches to health security have been most successful when narrowly defined, with the consequence that the distinction between all three approaches has become increasingly blurred.

These developments have provided the background for the emergence of an EU role in public health. The chapter has argued that three developments in particular have shaped the evolution of EU engagements in providing for public health protection: the growing number of actors involved in promoting health security on the international scene over the

course of the past 20 year and in particular, the WHO; a number of health challenges that have emerged over the same time period and that have drawn attention to the security risks associated with disease emergence; and the significance of communicable disease control for the EU integration project. The chapter has argued that the vulnerability to emerging infectious diseases fuelled by processes of globalization and by the open borders within the Union, along with the process of establishing the EU as a distinct economic and political entity, has provided the impetus for a growing preoccupation with health security within the Union. A series of crisis events, moreover, have spurred the formalization of EU competences in health protection, reflected in successive EU treaties and in the frameworks for action in public health.

The chapter has argued that health security in the context of the EU has primarily concerned ensuring the economic and political integrity of the Union as a whole, including protecting EU citizens from infectious disease circulation, and thereby is conceptually aligned with the (inter)national security approach to health security. The EU has emerged as an additional site where questions over jurisdiction and responsibility in managing the circulation of disease are being played out. The threat of pandemic influenza, moreover, has not been institutionalized as a security threat prior to EU engagement in the field of public health. Rather, as will be demonstrated in more detail in the following chapters, the process of securitizing pandemic influenza at the level of the EU has been integral to the evolving role of the EU in the domain of public health.

The significance of these developments for the purposes of this thesis is two-fold: First, the rise of health security internationally and the various approaches to the security-health nexus bring to the fore the significance of the strategic or pragmatic use of language

in elevating health on the international agenda, lending support to the use of securitization theory as a framework for analysis in this study. Second, these developments provide the contextual backdrop for the examination of the process of securitizing pandemic influenza at the level of the EU. The developments that have taken place internationally along with the concomitant developments at the level of the EU have thus played an important role in providing the conditions to effectuate securitization. In the case of the EU, this has included setting the parameters for the process of securitization itself. The next chapter explores this process of securitization in more detail by focusing on the emergence of an EU health security agenda and the concomitant constitution of pandemic influenza as a security threat in the years leading up to the outbreak of the influenza A(H1N1) pandemic in 2009.

Chapter 3: The process of securitizing pandemic influenza at the level of the EU

Introduction

The previous chapter explored the health-security nexus and the rise of the notion of health security internationally along with the emergence of an EU role in public health as a means of providing the contextual backdrop to the study of the securitization of pandemic influenza at the level of the EU. This chapter builds on the previous chapter by focusing on the process of securitizing pandemic influenza at Union level in the years leading up to the 2009 influenza A(H1N1) pandemic. The aim of the chapter is both to delineate the relevant actors engaged in shaping securitizing dynamics at the level of the EU and to account for securitizing moves and their outcomes. The next chapter focuses on the 2009 outbreak event itself and its impact on the securitization process identified in this chapter.

Drawing from the discussion on securitization theory in chapter one of this thesis, this chapter argues that the unique political features of the EU carries two consequences for the identification of securitizing processes at EU level: First, the constellation of actors involved in shaping what can be considered an evolving health security agenda at Union level are both narrow and specialized, consisting of experts, bureaucrats and politicians from the field of public health itself. As such, a clear and hierarchical distinction between actor and audience cannot be maintained. Rather, a securitizing actor has the potential to take on the role of audience and vice versa. Additionally, given the multiple avenues

through which securitizing processes can evolve and given the interactions that take place between various actors beyond the official pronouncements of institutions, the directional force between a particular securitizing move, its reception and subsequent policy outcome cannot necessarily be ascertained. The chapter argues, however, that by examining patterns of securitizing rhetoric and practice over time, it is possible to identify a process of securitization underway at the level of the EU with political effect.

Second, given the Union's limited power and regulatory nature, a successful securitization is unlikely to be expressed by the breaking free of otherwise binding rules, but rather by the push for further EU-level competences in governing the threat of disease. Securitizing moves in this context are not only based on a claim to extreme threat and urgency for action, but importantly, also on the need for that action to be taken at European level. The European Commission thus occupies a key position as a securitizing actor given the central role that the Commission plays as both a legislative initiator and a policy entrepreneur.

This push for further EU-level competence, however, does not only provide a means of accounting for processes of securitization in this specific political setting, but is also reflective of the nature of pandemic influenza as a particular threat subject. As a recurring challenge with cross-border potential, the threat of pandemic influenza requires cross-border collaboration to mitigate. Yet, while the threatening features of pandemic influenza may be broadly acknowledged, the need for a particular course of action or the urgency for action may not necessarily be recognised or sustained. On this point and in keeping with chapter one of this thesis, the chapter argues that the success of a securitization is not based on the recognised 'securityness' of the threat subject itself, but rather on the

collective willingness to act on that claim. In the case of the securitization of pandemic influenza at the level of the EU, a key theme underpinning the securitization process is the question as to what extent and in what capacity the threat of pandemic influenza should be managed at Union level. Thus, while by the end of 2008, pandemic influenza is broadly recognised as a distinct threat subject and the need for formalized and coordinated EU level action is recognised as necessary in response, a recurring point of negotiation throughout this process of securitization is the extent of Community involvement in managing an area that remains primarily in Member States' domain.

The chapter argues that the process of securitizing pandemic influenza at Union level has been crisis driven. Three events in particular have shaped what this chapter identifies as an evolving health security agenda at the level of the EU: the anthrax attacks in the United States in 2001; the outbreak and spread of Severe Acute Respiratory Syndrome (SARS) in 2002-2003; and the re-emergence and spread of the avian influenza virus between 2004 and 2005. Each of these events served to redirect attention and activities at the level of the EU and signalled clear turning points in the development of cooperative arrangements aimed at countering the threat of communicable disease within the Union. The anthrax attacks and the outbreak of SARS provided additional contextual support to claims as to the criticality of an emergent pandemic influenza with the resurgence of H5N1 in 2004-2005. Both of these events resulted in a set of iterative claims and practices that provided a basis for subsequent claims as to the securityness of pandemic influenza and the need for coordinated efforts to confront it. All three of these events underscore the role of external contextual developments in lending credence to securitizing claims made, supporting Balzacq's assertion that an audience is more likely to accept a securitizing claim if times are

critical enough.[247] These three events thus brought to the fore the potential security implications of a pandemic eventuality and served to propel the process of securitization at Union level forward.

The chapter begins by identifying the constellation of actors involved in shaping securitizing dynamics at EU level. Next, attention turns to the three crisis events that have shaped the evolution of the health security agenda at Union level and concomitantly, the process of securitizing pandemic influenza. These events are the 2001 anthrax attacks, the 2002-2003 outbreak and spread of SARS, and the 2004-2005 resurgence and spread of the H5N1 avian influenza virus. In each instance, focus falls on the interrelation between securitizing moves and the crisis event itself, and the outcome of both for the securitization process. Important to note here is that while the spread of disease is also linked to animal health and food safety issues in the EU, the focus of analysis in this case study is on the link between disease and public health specifically. As such, activities underway in the realms of animal health and food safety only receive cursory mention and for the most part, fall out of the scope of analysis. The chapter concludes with a summary of the chapter's findings and what they suggest about the securitization of pandemic influenza at the level of the EU.

The EU, actor(s), audience(s) and securitizing moves

As discussed in chapter one of this thesis, the EU is a context distinct from that of the domestic political setting underpinning the Copenhagen School's theory of securitization. Neither an international organization nor a state, the EU lacks the expertise and resources

[247] Balzacq, 'The Three Faces of Securitization', p. 182.

of the former and the capacity and social capital of the latter.[248] The EU thereby does not have the competence of the sovereign state to allow political leaders to declare the exception, nor is there a clear and hierarchical distinction between actor and audience. Functioning in large part as a regulatory state, the EU consists rather of 'several foci of political authority and leadership', the consequence of which is a lack of overall policy coherence or 'a clear and consistent policy direction' at EU level.[249] Policy processes differ across policy domains, as do the roles and responsibilities of the various actors engaged in these processes.[250]

The consequence of these features for the identification of securitizing processes at EU level is two-fold. First, the decentralised and fragmented nature of the EU polity means not only that discussion on policy tends to take place between a narrow and specialized group of actors at EU level, but also that public involvement in EU decision-making tends to be limited and thereby 'less relevant in an EU context than it might be in other polities.'[251] As public health experts and practitioners are the ones responsible for preparing for and responding to a health crisis in the first instance, when it comes to the promotion of health security at EU level it is amongst these experts and practitioners, along with the relevant bureaucrats and politicians that securitizing dynamics are likely to be located.

Second, given the limits set on the power of the Union and the EU's characteristically regulatory nature, the possibility of breaking free of otherwise binding rules is unlikely. The European Commission, as the representative agent of the EU and thereby a key securitizing

[248] Mossialos, Permanand, Baeten & Hervey, *Health Systems Governance in Europe*, p. 231.
[249] Nugent, N. *The Government and Politics of the European Union* 7th edition (Houndmills, Basingstoke & New York: MacMillan, 2010), p. 287.
[250] Nugent, *The Government and Politics of the European Union* 7th edition, p. 289.
[251] Neal, 'Securitization and Risk at the EU Border', p. 336; Princen, S. & M. Rhinard. 'Crashing and creeping: agenda-setting dynamics in the European Union', *Journal of European Public Policy* 13(2006), p. 1121.

actor, can act only where the legal basis exists for it to do so and is constrained by the resources available to it.[252] EU-level action is thus qualified by the principles of subsidiarity and proportionality, meaning that EU-level intervention is warranted where, due to the scale and effect of an action, there is an added value and where action is 'proportionate to the objectives to be achieved.'[253] Thus, as Robyn Martin and Alexandra Conseil have pointed out, while the EU has gained a growing role in public health, any infringement on the principle of subsidiarity needs to be justified 'either on the grounds of necessity (in that a stated objective cannot be achieved by EU states alone) or on the grounds of added value (in that the objectives can be better achieved by the EU than by an international body).'[254] The securitization of pandemic influenza at the level of the EU, then, is not likely to be expressed by the breaking free of otherwise binding rules, but rather by the push for further EU-level competences in governing the threat of disease. Moreover, any securitizing move evidenced in this context is likely to be based at least in part on an argument of EU added value. A key tension that arises out of the securitization process is thereby the extent to which actors feel that the EU should be given these competences.

The four main bodies involved in shaping securitizing dynamics at the level of the EU are the European Commission, the European Council, the Council of the European Union (herein also referred to as the Council or the Council of Ministers) and the European Parliament (EP). The European Commission, as the supranational body representing the Union, has both a legislative and an administrative role. In addition to having a central role in the policy-making process through both the initiation and development of policy and

[252] Cremona, M. 'The EU and Global Emergencies: Competence and Instruments', in *The European Union and Global Emergencies: A Law and Policy Analysis*, edited by Antonis Antoniadis, Robert Schütze & Elanore Spaventa (Oxford & Portland: Hart Publishing, 2011), pp. 11-12.
[253] *Consolidated Version of the Treaty on European Union*. OJ C 83/18, 30.3.2010.
[254] Martin & Conseil, 'Public Health Policy and Law for Pandemic Influenza', p. 1098.

legislation, the Commission is responsible for the monitoring and coordination of EU policies, for ensuring Treaty compliance, and for representing the EU externally.

Organizationally, the Commission's structure reflects the fragmented and decentralised nature of the Union. The Commission is composed of a political branch (the College of Commissioners) and an administrative branch (the Commission services). The Commissioners of the College are each responsible for a particular policy portfolio, represented by a Directorate-General (DG) and headed by a Director-General. While the College of Commissioners is responsible for taking the final decision on proposals, including decisions on issues unresolved at the lower levels of the Commission services at the last instance, the Commission services is primarily responsible for the preparation of policy proposals.[255] It is thus the Directorate-General for Health and Consumer Affairs (DG SANCO) that is primarily responsible for issues pertaining to public health.

While the Commission has exclusive rights to legislative initiation, on other measures, this power is shared with the other EU bodies and in particular, with the Council.[256] The Council, as the intergovernmental body representing national governments of the Member States, is primarily responsible for taking policy and legislative decisions in the Union and thus functions as 'the central law-making body in the EU.'[257] However, the Council can also spur the initiation of policy by either requesting the Commission to undertake a study on a particular issue or by adopting its own opinions, resolutions, agreements or recommendations. While these measures are not legally binding, they do

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[255] Egeberg, M. 'The European Commission', in *European Union Politics* 2nd edition, edited by Michelle Cini (Oxford: Oxford University Press, 2007), p. 143.
[256] Hervey & McHale, *Health Law and the European Union*, p. 48; Nugent, *The Government and Politics of the European Union* 7th edition, p. 121.
[257] Nugent, *The Government and Politics of the European Union* 7th edition, p. 139; Hervey & McHale, *Health Law and the European Union*, p. 48.

carry political weight and are difficult for the Commission to ignore.[258] Additionally, the Council can request the Commission to prepare proposals for legislation – a request to which the Commission is obliged to respond. The Council is thus not only an empowered audience in the sense that it has a direct causal connection to the issue at hand and has the capacity to grant the Commission, as a securitizing actor, the ability to take a particular course of action, but can also exercise agency in the sense that it can instigate a course of action through its role as policy initiator. By requesting the Commission to pursue a particular course of action, the Council can also provide the Commission with the platform from which to make securitizing moves.

Organizationally, the Council consists of nine different formations, each one representing a different policy domain and made up of a Council of Ministers relevant to that specific policy area. The Ministers of Health from each Member State meet under the Employment, Social Policy, Health and Consumer Affairs Council (EPSCO) configuration and deal with matters pertaining to public health. As the Council is legally considered one entity, however, any formation of the Council can adopt a text irrespective of its content provided that consensus exists. The various Ministers on the Council are supported by Permanent Representations, made up of ambassadors and state officials who prepare the majority of the Council's work as part of the Council's Permanent Representative Committee (COREPER).[259]

While COREPER functions as the preparatory body for the Council, the Council of Ministers undertakes formal ratification of decisions and negotiations on sensitive or

[258] Nugent, *The Government and Politics of the European Union* 7th edition, p. 140.
[259] Gowland, D., R. Dunphy & C. Lythe. *The European Mosaic* 3rd edition (Essex: Pearson Education, 2006), p.329.

controversial issues. Committees and Working Parties can also be established or approved of by COREPER in order to aid with preparatory work or undertake specific studies as deemed necessary. These committees and working parties are comprised of officials from the Member States with expertise in the issue area with which the committee or working party is concerned. Thus, the Working Party on Public Health focuses on issues pertaining to public health and medical care, while the Working Party on Pharmaceuticals and Medical Devices focuses on draft legislation in these two areas. The Council Presidency, held by a Member State government and rotating every six months, also plays an important role in shaping the Council's policy direction. As the Presidency is responsible for chairing and setting the agenda for Council meetings, drafting Council Conclusions and representing the Council in dealings with other institutions, it can constitute 'an important source of leadership in the EU' and can push the Council in particular policy directions or towards identified priorities or aims.[260]

The European Parliament shares the role of legislator with the Council under the ordinary legislative procedure – a procedure used for all major health legislation – and thus also exercises influence over the form that legislation may take.[261] The Parliament can also influence the development of EU-level activities through the passing of non-binding resolutions, through its joint control of the EU budget with the Council, and through its role

[260] Lewis, J. 'The Council of the European Union', in *European Union Politics* 2nd edition, edited by Michelle Cini (Oxford: Oxford University Press, 2007), p. 160; Nugent, *The Government and Politics of the European Union* 7th edition, p. 150.

[261] The ordinary legislative procedure was known as the co-decision procedure prior to the Lisbon Treaty. The co-decision procedure was introduced by the Treaty of Maastricht and enables the Parliament up to two readings on a proposal from the Commission before a common decision between the Parliament and the Council has to be reached. Readings are usually undertaken by a relevant parliamentary committee, which in the case of matters pertaining to public health, is the Standing Committee on Environment, Public Health and Food Safety. If an agreement cannot be reached after two readings, the proposal is referred to a conciliation committee made up of representatives from both the Parliament and the Council. If the conciliation committee is unable to reach an agreement, the proposal fails.

in supervising the executive - i.e., the European Commission.[262] As the only directly elected European body, the Parliament consists of Members of the European Parliament (MEPs), who are elected every five years and who sit in transnational party groups determined broadly along the lines of similar political ideology.[263] The MEPs are divided into various Standing Committees that are responsible for undertaking the preparatory work of the Parliament. This work involves liaising with the Commission and the Council in the various stages of a legislative proposal, and developing non-legislative or own-initiative reports in the preparation for motions for resolution in the Parliament.[264] The Parliament can also create temporary committees or sub-committees to deal with specific issues as necessary, including formal committees of inquiry to investigate breaches in Community law under the Parliament's supervisory remit.[265] The Standing Committee on Environment, Public Health and Food Safety is the Committee primarily responsible for readings pertaining to public health.

The power of both the Parliament and the Council to spur the initiation of EU-level activities by either requesting the Commission to initiate proposals or by adopting their own non-binding measures means that the move for action on a particular issue amongst the three institutions is not necessarily unidirectional. As such, a clear and hierarchical distinction between securitizing actor and audience cannot be maintained. However, while both the Council and the Parliament can request the Commission to develop a proposal on a particular topic, the structure of both institutions makes it logistically difficult for either of

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[262] Nugent, *The Government and Politics of the European Union* 7th edition, p. 179.
[263] Scully, R. 'The European Parliament' in *European Union Politics* 2nd edition, edited by Michelle Cini (Oxford: Oxford University Press, 2007), p. 180.
[264] Nugent, *The Government and Politics of the European Union* 7th edition, p. 202.
[265] European Parliament. *Parliamentary Committees*. Available from: http://www.europarl.europa.eu/aboutparliament/en/00aab6aedf/Committees.html [Accessed on 01 March 2013].

them to develop initiatives themselves: '[The Council and the Parliament] tend often to be better at responding than at originating and proposing, which results in the Commission not only taking instructions from them but also using them to legitimate its own policy preferences.'[266] The Commission, as 'the pre-eminent policy entrepreneur in the EU' – or for the purposes of this thesis, the pre-eminent securitizing actor – thus 'actively frames policy proposals in order to construct political support.'[267]

A key feature of the Commission's policy and legislative activities, then, is the use of various types of committees in the preparation of policy and legislative proposals and in the implementation of agreed policies.[268] Under the system known as Comitology, committees of Member State representatives assist the Commission in the implementation of legislation. These committees are formally established on the basis of regulations, directives or decisions passed by the Council and/or the Parliament, and are significant for EU level governance in that they provide 'a means by which governments of member states and to a lesser extent the EP, seek to ensure the Commission does not become too independent of them.'[269] National epidemiologists and their counterparts thus sit on the Committee of the EU Network for the Surveillance and Control of Communicable Diseases, otherwise known as the Network Committee, established under Decision 2119/98/EC to assist the Commission in coordinating the network for epidemiological surveillance and control in the Union.

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[266] Nugent, *The Government and Politics of the European Union* 7th edition, p. 122.
[267] Young, A. 'The European Policy Process in Comparative Perspective', in *Policy-Making in the European Union* 6th edition, edited by Helen Wallace, Mark A. Pollack & Alasdair R. Young (Oxford: Oxford University Press, 2010), p. 53.
[268] Wallace, H. 'An Institutional Anatomy of Five Policy Modes', in *Policy-Making in the European Union* 6th edition, edited by Helen Wallace, Mark A. Pollack & Alasdair R. Young (Oxford: Oxford University Press, 2010), p. 75.
[269] Nugent, *The Government and Politics of the European Union* 7th edition, p. 130.

In addition to those committees that fall under Comitology, however, the Commission also draws on a number of other types of expert and advisory bodies, both formal and informal, in the development and implementation of proposals and legislation. A case in point in this regard is the Charter Group, an informal advisory body that was made up of heads of national surveillance centres in the EU and created in 1994 to assist in the development of collaborative arrangements on disease surveillance in the Union prior to Decision 2119/98/EC. The significance of these various types of bodies for securitizing processes at Union level lies not only in the fact that they provide a means of influencing policy initiation within the Commission, but also in that they provide a means of the Commission to test the receptiveness of particular initiatives before formally presenting them to the Council and the Parliament. Thus, while the focus of this thesis is on the interactions between the three EU institutions themselves in the process of securitizing pandemic influenza, the role and presence of these bodies in the policy-making process is noteworthy.

In addition to the interrelationship between the Commission, the Council and the European Parliament, however, securitizing dynamics at EU level are also influenced by the central role that the European Council occupies in political decision-making in the Union. The European Council is comprised of Heads of State and Government of the Member States, along with the President of the Commission. While not a formal EU institution and although lacking legislative power, the European Council can provide overall strategic guidance for the EU as well as direction on politically sensitive issues.[270] The European

[270] Lewis, 'The Council of the European Union', p. 158. The European Council is an 'extra-legal institution of the EU' and therefore sits independent of the three European Community institutions made up of the Commission, the Council of the European Union and the Parliament. Lewis, 'The Council of the European Union', p. 158.

Council can thus take on the role of securitizing actor by expressing the need for the EU to tackle a particular issue on the basis of a securitizing argument. Alternatively, the European Council can spur the initiation of a process of securitization on the basis of a particular call for action that is then taken up by the relevant DGs within the Commission services or within the relevant Commission expert groups and Council working parties. On this latter point, Sebastiaan Princen and Mark Rhinard have asserted that agenda-setting at EU level generally follows two ideal types: a 'high politics' route, expressed through pronouncements by political leaders in the European Council and usually spurred by a symbolic event, and a 'low politics' route that is primarily technocratic and involving the concerns of professionals working within the same issue area.[271] Framing, according to Princen and Rhinard, takes on significance at the technocratic level, as the detailed response to an issue is likely to reflect the sectoral biases and technical frames of the groups and working parties responsible for them.[272]

What this suggests, then, is not only that securitizing processes at EU level have the potential to evolve through a variety of avenues, but also are likely to involve a multiplicity of actors. These actors, however, are both narrow and specialized, reflecting the sectors or policy domains with which a particular issue is associated. In the case of the securitization of pandemic influenza, those actors primarily involved in shaping securitizing dynamics are public health experts, policy makers and practitioners from both the Commission and the EU Member States. Given the relatively exclusive nature of this group of actors and given the rules of interaction between the three EU institutions, a clear and hierarchical distinction

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Thus, when reference is made to the three EU institutions in this thesis, this does not include the European Council.

[271] Princen & Rhinard, 'Crashing and creeping', p. 1121.

[272] Princen & Rhinard, 'Crashing and creeping', pp. 1121; 1129.

between actor and audience cannot be maintained. The various opportunities for interactions between actors beyond the official communications issued by the institutions themselves, moreover, also suggests that the directional force between a securitizing move, its reception and outcome cannot always be determined. Nevertheless, as will be demonstrated in the next section of this chapter, by examining patterns of securitizing rhetoric and practice over time, it is possible to identify a process of securitization underway at EU level with political effect such that, by the end of 2008, pandemic influenza is not only recognised as a distinct threat subject, but formalized arrangements aimed at countering the threat at EU level are recognised as necessary in response. The European Commission, moreover, as a 'pre-eminent policy entrepreneur', has played a key role in propelling this securitization process forward.

The securitization of pandemic influenza and three crisis events

As a persistent and recurrent challenge with historical precedence, pandemic influenza seems amenable to what the Copenhagen School has described as an institutionalized securitization – that is, those instances where '[t]he need for drama in establishing a securitization falls away, because it is implicitly assumed that when we talk of this issue we are by definition in the area of urgency.'[273] In the case of an institutionalized securitization, according to the Copenhagen School, urgency has already been established in a previous securitizing move and it is thus not necessary to reiterate the argument for securitization, as reference to the threat subject itself will implicitly indicate 'security' or 'priority.'[274] Rather,

[273] Buzan et al., *Security*, p. 28.
[274] Buzan et al., *Security*, p. 28.

behind what appears to be normal politics, one is likely to 'find a – probably irritated – repetition of a security argument so well established that it is taken for granted.'[275]

Adam Kamradt-Scott and Colin McInnes have argued, however, that while pandemic influenza may have been 'historicized' as a security threat, the 1918 influenza pandemic serving as a 'watershed event' in this regard, the cyclical nature of influenza epidemics has corresponded with a process of securitization that has also been cyclical.[276] Rather than being institutionalized as a security threat, Kamradt-Scott and McInnes maintain that it was not until 1997 with the identification of the new H5N1 avian influenza virus strain in Hong Kong that a new process of securitizing pandemic influenza began – a process that once initiated, spanned the course of almost a decade before reaching successful completion.[277] The significance of Kamradt-Scott and McInnes' analysis for the purposes of this thesis is two-fold: First, it suggests that pandemic influenza can fall into and out of a securitized mode over time. The cyclical nature of pandemic influenza as a threat subject indicates, then, that while the securityness of pandemic influenza may not be disputed, the urgency for action implicit in a securitizing move may not be immediately endorsed or necessarily sustained. A key indicator of the success of a securitizing move is thereby not the recognised securityness of the threat subject itself, but rather the collective willingness to act on the securitizing claim.

Second, Kamradt-Scott and McInnes' analysis supports the argument made in both this chapter and the previous one that pandemic influenza has not been institutionalized as a security threat prior to EU-level engagement in the field of public health. Rather, as will be

[275] Buzan et al., *Security*, p. 28.
[276] Kamradt-Scott, A. & C. McInnes. 'The securitisation of pandemic influenza: Framing, security and public policy', *Global Public Health* 7(2012), pp. S96; S98.
[277] Kamradt-Scott & McInnes, 'The securitisation of pandemic influenza', p. S99.

demonstrated below, the recent process of securitizing pandemic influenza at EU level can be traced back to the end of the 1990s and the beginning of the 2000s, and has been spurred and propelled forward by a series of crisis events. Three events in particular have shaped the evolution of what can be considered a health security agenda at Union level and concomitantly, the securitization of pandemic influenza in the years leading up to the influenza A(H1N1) pandemic in 2009. These events were the anthrax attacks in the United States in 2001, the outbreak of Severe Acute Respiratory Syndrome (SARS) in 2002-2003, and the re-emergence and spread of the avian influenza H5N1 virus in 2004-2005. Each of these events signalled clear turning points in the development of cooperative arrangements in combating the threat of disease emergence in the Union and provided a new basis for securitizing moves in years to come. While the anthrax attacks led to the creation of the Health Security Committee (HSC), the outbreak of SARS served to fast track the establishment of the European Centre for Disease Prevention and Control (ECDC). Both of these events provided a contextual backdrop that lent support to the perceived criticality of a pandemic eventuality with the resurgence of H5N1 in 2004-2005 – an event that instigated a renewed urgency to coordinate on pandemic preparedness planning within the Union.

Throughout this time period, moreover, it is possible to identify the gradual development of an articulated threat subject at EU level, informed and propelled forward by these crisis events. By the end of 2008, pandemic influenza is recognised as not just constituting a source of vulnerability, but rather as a threat to EU citizens and the economy and political stability of the Union as a whole. Additionally, the need to formalize EU level arrangements in providing for health security within the Union is recognised as a necessary

measure in response. It is to these events and their significance for the process of securitizing pandemic influenza at EU level that attention now turns.

The 2001 anthrax attacks and the creation of the Health Security Committee

The anthrax attacks in the United States followed closely on the heels of the 11 September 2001 attacks. Between mid-September and November 2001, letters containing anthrax were sent through the US postal service to a number of news media offices and to two US Congressmen. Five individuals died from contact with the anthrax, while 22 others fell ill. The anthrax contained in the envelopes was of a common genetic strain, but had undergone attempts at weaponization through treatments meant to increase its ability to aerosolize. While this suggested that the anthrax likely originated from a US bioweapons research facility, the perpetrator(s) of the attacks remained initially unknown.[278]

The anthrax attacks brought the issue of bioterrorism to the fore of the political agenda both at the level of the EU and internationally. In Europe, while there were no cases of anthrax, a number of items sent through the mail suspected or claimed to be contaminated with anthrax put civil protection and security officials and public health systems on alert.[279] Internationally, health officials from the European Commission, Canada, France, Germany, Italy, Japan, Mexico, the United Kingdom, the United States and the WHO convened to form the Global Health Security Initiative (GHSI) – an informal group initially envisaged by former United States Secretary for Health and Human Services, Tommy

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[278] Johnson, Wm. R. *Review of Fall 2001 Anthrax Bioattacks*, 17 March 2005. Available from: http://www.cdc.gov/niosh/nas/rdrp/appendices/chapter6/a6-45.pdf [Accessed on 7 March 2013].

[279] Commission of the European Communities. *Communication from the Commission to the Council and the European Parliament on Cooperation in the European Union on Preparedness and Response to Biological and Chemical Agent Attacks (Health Security).* COM(2003) 320 final. Brussels, 2.6.2003, p. 5.

Thompson, as a means of improving global health security through coordination and information sharing amongst 'like-minded countries' concerned with the threat of bioterrorism.[280] At the first ministerial meeting in Ottawa, Canada on 7 November 2001, those in attendance adopted a Ministerial Statement that condemned the anthrax attacks in the United States and resolved to take action to enhance health security. The opening paragraphs of the Statement read as follows:

> 1. We, Health Ministers/Secretaries/Commissioner, have consistently condemned in the strongest terms all forms of biological, chemical and radio-nuclear terrorism and in particular the acts of terrorism that have taken place in the United States. We affirm our resolve as a group of Health Ministers/Secretaries representing diverse nations to, individually and collectively, take concerted actions to ensure the health and security of our citizens, and to enhance our respective capacities to deal with public health incidents.
>
> 2. The events of September 11 have changed the focus of governments. It has centred our attention on how we assess risks, how we prepare for any eventuality and how we respond more effectively to public health security crises. It has added urgency and determination to further strengthen our plans, networks and protocols in collaboration with other countries as well as international organizations. Terrorism, particularly bioterrorism, is an international issue, for instance, an outbreak of smallpox anywhere in the world is a danger to all countries. International collaboration is essential.[281]

The threat posed by the deliberate release of biological agents, as demonstrated by the anthrax attacks, was also reflected in a 2002 World Health Assembly (WHA) Resolution entitled *Global public health response to natural occurrence, accidental release or deliberate use of biological and chemical agents or radionuclear material that affect health*. Making

[280] Global Health Security Initiative. *GHSI Background.* Available from: http://www.ghsi.ca/english/background.asp [Accessed on 4 March 2012].

[281] Global Health Security Initiative. *Ministerial Statements: Health Ministers Take Action to Improve Health Security Globally*, November 2001. Available from: http://www.ghsi.ca/english/statementottawanov2001.asp [Accessed on 4 March 2012].

reference to a Resolution adopted the previous year on the strengthening of global epidemic alert and response capacities, the 2002 Resolution reinforced the need for WHO Member States to establish national disease surveillance plans, to collaborate on surveillance data and 'to treat any deliberate use, including local, of biological and chemical agents and radionuclear attack to cause harm as a global public health threat.'[282]

Within the EU, the anthrax attacks were the first time that the EU seriously engaged with the microbial world as a threat to security. Whereas in previous years the possibility of communicable disease emergence was primarily acknowledged as a source of vulnerability, the anthrax attacks marked a shift in language and introduced the term health security to the EU lexicon. The attacks spurred the convening of an extraordinary European Council meeting in Ghent, Belgium on 19 October 2001. Heads of State and Government and the President of the Commission condemned the attacks in the United States and called for more cooperation in countering terrorism. This included requesting the Commission and the Council to prepare a programme to improve cooperation on preparedness and response to chemical and biological attacks in the Community.[283] The European Council Declaration stated:

> 5. The European Council has examined the threats of the use of biological and chemical means in terrorist operations. These call for adapted responses on the part

[282] World Health Assembly. *Global public health response to natural occurrence, accidental release or deliberate use of biological and chemical agents or radionuclear material that affect health*. WHA55.16, 18 May 2002. For the 2001 Resolution, see World Health Assembly. *Global health security: epidemic alert and response*. WHA54.14, 21 May 2001.
[283] Princen & Rhinard, 'Crashing and creeping', p. 1126; European Council. *Declaration by the Heads of State or Government of the European Union and the President of the Commission: Follow-up to September 11 Attacks and the Fight Against Terrorism.* SN 4296/2/01, Brussels, 19 October 2001, pp. 1-5; Commission of the European Communities. *Communication from the Commission to the Council and the European Parliament*: *Civil protection – state of preventive alert against possible emergencies*. COM(2001) 707 final. Brussels, 28.11.2001, p. 2.

> of each Member State and of the European Union as a whole. No attack of this kind has occurred in Europe. The authorities will maintain increased vigilance and cooperation between the intelligence, police, civil protection and health services will be stepped up.
>
> In tandem with the measures already taken, the European Council asks the Council and the Commission to prepare a programme to improve cooperation between the Member States on the evaluation of risks, alerts and intervention, the storage of such means, and in the field of research. The programme should cover the detection and identification of infectious and toxic agents as well as the prevention and treatment of chemical and biological attacks. The appointment of a European coordinator for civil protection measures will be part of the programme.
>
> The Member States will react firmly with regard to any irresponsible individuals who take advantage of the current climate to set off false alarms, particularly by applying severe criminal penalties for such offences.[284]

The anthrax attacks thus served as a focusing event that drew political attention specifically to the issue of bioterrorism, instigating a call for further EU action from the highest political level in the Union.[285]

Within the lower echelons of the Commission and the Council, national health experts responded to the European Council's call by framing the anthrax attacks as a threat to public health, thereby drawing a direct link between public health protection and security. Princen and Rhinard have maintained that national health experts downplayed the criminal aspects of bioterrorism, emphasising the 'health exigencies of a biological release (intentional or not).'[286] This differed from experts from Justice and Home Affairs, who emphasized the criminal element of bioterrorism and the need to prevent such acts from occurring, and actors from national agencies dealing with emergency services who approached the issue in terms of consequence management and the need to build

[284] European Council, *Follow-up to September 11 Attacks and the Fight against Terrorism*, p. 4.
[285] Princen & Rhinard, 'Crashing and Creeping', p. 1126.
[286] Princen & Rhinard, 'Crashing and creeping', p. 1127.

resilience and enhance civil protection systems.[287] In fact, Princen and Rhinard have asserted that those pushing a health security frame 'resisted a drive by the police and intelligence community to include health proposals as part of internal security plans' out of fear of a loss of control over an issue considered to fall within their remit.[288] The framing of bioterrorism as a threat to public health, then, served as a strategic means of promoting the need to strengthen public health preparedness and response capacities by public health experts in the Union, while ensuring that public health officials remained central to these efforts.

Thus, in a Council meeting of Health Ministers held on 15 November 2001 to discuss bioterrorism, the Council reiterated the need for an action programme on cooperation and preparedness. The Council Presidency Conclusions invited the Commission to develop such a programme and called for increased cooperation and coordination between Member States. The opening paragraphs of the Council Presidency Conclusions on bioterrorism stated the following:

1. The Presidency notes the cardinal role of public health bodies in the fight against bioterrorism.

2. It desires a strengthening of the EU's response capacity by means of more effective cooperation and coordination between Member States with the support of the Commission, in particular on the basis of the declaration adopted by the Heads of State or Government at Ghent on 19 October 2001, in cooperation with the relevant international organisations.

3. The Presidency welcomes the concrete steps already taken to strengthen the European communicable diseases network and the early warning system

[287] Princen & Rhinard, 'Crashing and creeping', p. 1127.
[288] Princen & Rhinard, 'Crashing and creeping', p. 1128.

> (Decision 2119/98/EC), and it invites the Member States and the Commission to develop a comprehensive programme of cooperation.[289]

While the Presidency Conclusions does not explicitly frame bioterrorism as an extreme threat to the Union requiring immediate action and thereby does not follow the logic of a securitizing move, it does constitute a response to the heightened priority given to the issue of bioterrorism signalled by the European Council Declaration adopted at Ghent. Moreover, in emphasising the central role of public health in countering bioterrorism in the Union, the Presidency Conclusions linked the European Council call for action specifically to the need to enhance public health response capacities in the EU in addressing the threat posed by bioterrorism. Amongst the recommended initiatives outlined in the Presidency Conclusions was the creation of 'a European network of experts responsible for evaluating, managing and communicating risks' in addressing the health aspects of the threat of terrorism.[290]

At the time of the Council Presidency Conclusions' adoption, the initiatives outlined in the Conclusions were already underway. In keeping with the recommendation for a network of experts charged with evaluating, managing and communicating risks, the Commission, following a meeting between Health Ministers and Commissioner for Health and Consumer Protection, David Byrne, on 26 October 2001, created the Health Security Committee (HSC). An informal committee with no legal standing and made up of high-level representatives of health ministers and the Commission, the HSC was initially tasked with facilitating the exchange of information on health-related threats, sharing information and experience on preparedness and response plans and crisis management strategies, and

[289] Council of the European Union. *2384th Council Meeting – Health*. C/01/415. Brussels, 15 November 2001, p. 3.
[290] Council of the European Union, *2384th Council Meeting – Health*, p. 11.

providing rapid communication in the event of a health-related crisis.[291] The HSC formed a part of a Commission proposed programme on cooperation on preparedness and response to biological and chemical agent attacks (health security), requested by Health Ministers at the 15 November 2001 Health Council meeting and agreed upon by the HSC on 17 December 2001.[292]

The details of the new health security programme, code-named BICHAT, were provided in a 2003 Commission Communication on health security, the aim of which was to outline the measures underway amongst Health Ministers and the Commission to address the health aspects of bioterrorism and the preparedness and response challenges facing the health sector.[293] The health security programme constituted one component of a series of coordinated actions undertaken by the Commission that spanned the civil protection and health fields, as well as the enterprise, research, nuclear, transport and energy fields.[294] These developments, including the creation of the civil protection co-ordination mechanism and the extension of the communicable disease surveillance networks to include pathogenic agents that could be used in a biological attack, were outlined in two earlier Commission Communications. The first Communication was issued on 28 November 2001 and focused on civil protection and the state of preventive alert against 'all types of emergency', while

[291] Commission of the European Communities, *Communication on Cooperation in the European Union on Preparedness and Response to Biological and Chemical Agent Attacks (Health Security)*, pp. 8-9.
[292] Council of the European Union. *Transmission Note: Programme to improve co-operation in the European Union for protecting the population against bacteriological, chemical, radiological or nuclear (BCRN) threats – Contribution of the Working Party on Public Health*. SAN 154/PROCIV 80. Brussels, 9 October 2002, p. 2.
[293] Commission of the European Communities, *Communication on Cooperation in the European Union on Preparedness and Response to Biological and Chemical Agent Attacks (Health Security)*, p. 13.
[294] Commission of the European Communities, *Communication on Cooperation in the European Union on Preparedness and Response to Biological and Chemical Agent Attacks (Health Security)*, p. 6.

the second was issued on 11 June 2002 and documented the progress made in civil protection and preventive alert in the Union.[295]

The overall aim of the health security programme was '[t]o coordinate and support the public health/health security preparedness and response capacity and planning of the Member States against biological and chemical agent attacks.'[296] The objectives of the programme were four-fold:

(a) Set up a mechanism for information exchange, consultation and co-ordination for the handling of health-related issues related to attacks;

(b) Create an EU-wide capability for the timely detection and identification of biological and chemical agents that might be used in attacks and for the rapid and reliable determination and diagnosis of relevant cases;

(c) Create a medicines stock and health services database and a stand-by facility for making medicines and health care specialists available in cases of suspected or unfolding attacks;

(d) Draw-up rules and disseminate guidance on facing-up to attacks from the health point of view and co-ordinating the EU response and links with third countries and international organisations.[297]

The Health Security Committee constituted one component of the coordination mechanism of alert and information exchange under the health security programme. The

[295] Commission of the European Communities, *Civil protection – state of preventive alert against possible emergencies*; Commission of the European Communities. *Communication from the Commission to the Council and the European Parliament: Civil protection – Progress made in implementing the programme for preparedness for possible emergencies*. COM(2002) 302 final. Brussels, 11.6.2002.
[296] Commission of the European Communities Health and Consumer Protection Directorate-General. *Programme of Cooperation and Preparedness and Response to Biological and Chemical Agent Attacks [Health Security]*. G/FS D(2001) GG. Luxembourg, 17 December 2001, p. 1.
[297] Commission of the European Communities, *Communication on Cooperation in the European Union on Preparedness and Response to Biological and Chemical Agent Attacks (Health Security)*, p. 8.

responsibilities of the HSC were specified in the 2003 Commission Communication as follows:

- address at short notice and coordinate together with the Commission all responses in terms of public health related to attacks in which biological and chemical agents might be used;
- exchange information on plans and arrangements for preparedness and response;
- consider and provide advice on all aspects of public health preparedness for emergencies related to such attacks, and help in the implementation at Member State level of arrangements and strategies that may be agreed at EU level.[298]

The other component of the coordination mechanism was a rapid alert system (RAS-BICHAT), made operational in June 2002. RAS-BICHAT was linked on the one hand, to the early warning and response system created by Commission Decision 2000/57/EC under Decision 2119/98/EC establishing the Network for surveillance and control of communicable disease in the Community, and on the other hand, to the civil protection mechanism, designed to improve the coordination of civil protection assistance at Community level.

The health security programme thereby constituted the response from health officials to the European Council's call for further cooperation following the anthrax attacks in the United States. The programme contributed to the Community's civil protection and preventive alert activities aimed at creating a generic preparedness capacity to respond to

[298] Commission of the European Communities Health and Consumer Protection Directorate-General, *Programme of Cooperation and Preparedness and Response to Biological and Chemical Agent Attacks [Health Security]*, p. 2.

'all types of emergency.'[299] The intensification of emergency planning was flagged in the 2003 Commission Communication as a priority under the health security programme and included compiling national emergency plans as a means of coordinating on specific measures in countering the threat of bioterrorism as well as conducting an EU-wide exercise, held on 19-20 October 2005, to test communication and compatibility plans across the Union.[300] A significant component of the new health security programme was the establishment of the Health Security Committee. Although an informal committee, the HSC comprised a key mechanism for the coordination of public health responses to generic emergencies and chemical, biological, radiological and nuclear (CBRN) threats within the Union. The HSC thereby signalled the development of further cooperative arrangements at Union level to address the public health aspects of the threat posed by pathogenic agents to the Union.

The anthrax attacks in the United States, then, triggered the further coordination of efforts to bolster public health protection within the Union, linking the protection of public health explicitly to efforts aimed at countering the threat of bioterrorism. Described in both the 2001 Commission Communication on generic preparedness planning and the 2003 Commission Communication on health security as a 'new type of threat', requiring 'specific preparedness plans...which go beyond what has so far been established to face threats from diseases,' the threat of bioterrorism introduced the notion of health security to

[299] See Commission of the European Communities, *Civil protection – state of preventive alert against possible emergencies*; Commission of the European Communities, *Civil protection – Progress made in implementing the programme for preparedness for possible emergencies*.

[300] Commission of the European Communities, *Communication on Cooperation in the European Union on Preparedness and Response to Biological and Chemical Agent Attacks (Health Security)*, p. 13. For a report on the EU-wide exercise, see Health Protection Agency. *Exercise New Watchman: Final Exercise Report*. March 2006. Available from: http://ec.europa.eu/health/ph_threats/com/watchman.pdf [Accessed on 31 March 2013].

communicable disease control within the EU.[301] Health security was understood in this instance as the preparation of the health sector against the threat of the deliberate or accidental release of chemical or biological material. Although not following the strict logic of a securitizing move, the efforts to frame bioterrorism as a threat to public health by public health experts and officials in and around the Council and the Commission provided a means of promoting the central role of public health in combating the threat of biological attack. The establishment of the HSC, moreover, introduced a new intergovernmental body at EU level charged with coordinating and advising on preparing for and responding to a potential biological or chemical release in the Union. This new intergovernmental body would provide a basis for further EU-level developments in years to come.

The outbreak of SARS and the establishment of the ECDC

While the anthrax attacks in the United States in 2001 served to mobilize health ministers to coordinate activities to address the public health aspects of bioterrorism, health protection arrangements at EU level were put to the test in 2002-2003 when a novel virus creating acute respiratory distress emerged and began rapidly travelling around the globe. Believed to have first emerged in Guangdong Province, China in November 2002, SARS (Severe Acute Respiratory Syndrome) raised international alarm when, on 12 March 2003, the World Health Organization made an unprecedented move and issued a global alert about cases of atypical pneumonia. By 15 March 2003, new suspected cases of the virus had been reported

[301] Commission of the European Communities, *Communication on Cooperation in the European Union on Preparedness and Response to Biological and Chemical Agent Attacks (Health Security)*, p. 4; Commission of the European Communities, *Civil Protection – State of preventive alert against possible emergencies*, 5.

in Canada, China, Hong Kong, Indonesia, the Philippines and Vietnam.[302] The rapid international spread of the novel virus reinforced the sense of global vulnerability to emergent pathogens. In an address given to the European Parliament on 7 April 2003, the Commissioner for Health and Consumer Protection, David Byrne, described the challenge posed by SARS as follows:

> SARS…demonstrates very clearly that we are living in a truly global environment, where the increasing mobility of people also enables diseases to move ever more freely.
>
> Because of the ease and extent of modern travel, an increasing level of preparedness is required across borders to deal with the threat posed by communicable diseases. In the European Union, surveillance and coordination at Community level need to be strengthened to address the threat to public health.[303]

Within the EU, SARS highlighted the disorganized nature of the European response to the challenges posed by emerging infectious diseases, made obvious by such instances as inconsistent and uncoordinated screening practices amongst Member States. The novel makeup of the SARS virus, its rapid global spread, and the impact it had on such wealthy countries as Canada, instilled, according to Scott Greer, a political impetus to 'do something' at EU level.[304] SARS thus led public health experts and officials in the EU to press for the further strengthening of surveillance and control efforts in the Community and most significantly, served to fast track the establishment of the European Centre for Disease

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[302] World Health Organization. *Severe Acute Respiratory Syndrome (SARS) Multi-Country Outbreak – Update 31, 16 April* 2003, quoted in Fidler, D., *SARS, Governance and the Globalization of Disease* (Houndmills, Basingstoke & New York: Palgrave Macmillan, 2004), p. 78.

[303] European Parliament. *Sitting of Monday, 7 April 2003*. Available from: http://www.europarl.europa.eu/RegData/seance_pleniere/compte_rendu/traduit/2003/04-07/P5_CRE(2003)04-07_DEF_EN.pdf [Accessed on 31 March 2013], p. 10.

[304] Greer, 'The European Centre for Disease Prevention and Control', p. 1008.

Prevention and Control (ECDC). The establishment of the ECDC was a significant step in the securitization process in that it marked the creation of a centralised agency charged with risk assessment in the Union. While the possibility of a Centre had been raised in the past, the combination of securitizing rhetoric from the Commission and of external contextual developments that gave credence to these claims provided the sense of criticality necessary to facilitate the creation of the ECDC in 2005.

The possibility of establishing a centre for the surveillance and control of communicable diseases in the Community was first raised in the late 1990s. During that time period, the Charter Group – an informal group of heads of national communicable disease centres established in 1994 – began meeting in cooperation with the Commission to collaborate on, and identify priorities in strengthening communicable disease surveillance in the Union.[305] At the same time, a number of infectious disease specialists from countries across Europe began advocating for the establishment of a European centre for infectious diseases in the pages of medical journals.[306] While the creation of a central structure for the surveillance and control of communicable diseases at Union level had the support of the European Parliament at the time, preference for a European centre was ultimately split and the Network for the Epidemiological Surveillance and Control of Communicable Diseases in Europe, otherwise known as the Communicable Diseases Network (CDN), was established under Decision 2119/98/EC as an alternative arrangement.[307]

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[305] Greer, 'The European Centre for Disease Prevention and Control', p. 1006; Giesecke, J. & J. Weinberg, 'A European Centre for Infectious Disease?', *The Lancet* 352(1998), p. 1308.

[306] Greer, 'The European Centre for Disease Prevention and Control', p. 1006. See, for example, Dove, A. '"European CDC" lobbies for support', *Nature Medicine* 4(1998), p. 1214; Tibayrenc, C. 'European centres for disease control', *Nature* 389(1997), p. 433; Tibayrenc, C. 'Microbes Sans Frontières and the European CDC', *Parasitology Today* 13(1997), p. 454.

[307] Greer, 'The European Centre for Disease Prevention and Control', pp. 1007-8; Giesecke & Weinberg, 'A European Centre for Infectious Disease?', p. 1308.

The issue of the creation of a European Centre for Disease Prevention and Control was raised again in 2002, this time by the Commission following a series of external evaluations initiated by the Commission that exposed weaknesses in the existing communicable disease surveillance structures in the Union.[308] Following the evaluations, the Commission sought the views of member state epidemiologists in June 2002 and again in November 2002 at a public seminar held under the auspices of the European Parliament, as well as the views of the Network Committee following an internal evaluation of the Communicable Diseases Network. In both instances, support was given to the creation of a central coordinating structure for the surveillance of communicable diseases in the EU, although Greer has suggested that there may have been some discrepancy in the conduct of the external and internal evaluations themselves.[309]

The outbreak of SARS provided the Commission with the further impetus to push for the establishment of the ECDC, adding an element of criticality to the Commission's arguments for a Centre. Thus, while officials in the Commission had already begun working on a proposal to submit to the Council and the European Parliament, Commissioner Byrne's immediate response to the outbreak of SARS was to appeal for the need for a European Centre and to announce the plans for a proposal to both the Parliament and to the Network Committee.[310] At the European Parliament session on 7 April 2003 mentioned earlier, in addition to highlighting the threat posed by SARS to the Community, Commissioner Byrne

[308] Commission of the European Communities. *Proposal for a Regulation of the European Parliament and of the Council Establishing a European Centre [for Disease Prevention and Control]*. COM(2003) 441 final/2. Brussels, 16.9.2003, pp. 2; 5-6.
[309] Greer has suggested that while the external evaluators held an advantage in terms of academic status and publication records, groups in the Commission were possibly interested in different answers than the external evaluators and therefore sought different kinds of evaluations. Greer, 'The European Centre for Disease Prevention and Control', p. 1008.
[310] Greer, 'The European Centre for Disease Prevention and Control', p. 1010; Rogers, A. 'Europe contemplates US-style disease-control centre', *The Lancet* 361(2010), p. 1625.

argued for the need to establish a European Centre for Disease Prevention and Control as a means of strengthening EU capacities to address outbreaks such as SARS. Commissioner Byrne stated:

> I must stress that the capacity of the Commission to extend its coordinating and facilitating role any further is currently at its very limit. In the absence of new arrangements to pool the existing expertise we will not be able to go beyond our current efforts. I have referred on many occasions to our plans to strengthen our capacity to deal with communicable diseases.
>
> In my view, the most effective way to strengthen Community activities is to set up a European Centre for Disease Prevention and Control. As many of you will be aware, we are well advanced in the preparation of the enabling legislation which I intend to table in the next couple of months. My proposal will be to establish such a centre by 2005.
>
> The centre will enhance surveillance. It will coordinate and facilitate common responses, and collaborate with Member States, third countries and international organisations, in particular the WHO. It will not replace existing national capacities, but rather hook them up to act as a reference and coordination point both in routine and crisis situations. This will also play an important role in an enlarged Europe.[311]

Taken alongside Commissioner Byrne's remarks cited earlier about the threat posed by communicable diseases as demonstrated by SARS, Commissioner Byrne's speech showed elements of a securitizing logic, although not explicitly stated in the form of a securitizing move in the Copenhagen School's understanding of securitization. Communicable diseases were described as posing a threat to the Union, requiring a strengthened and coordinated Community response. The current limited capacity of the Commission to fulfil its coordinating role suggests an element of criticality in addressing the limitations of current

[311] European Parliament, *Sitting of Monday, 7 April 2003*, pp. 10-11.

arrangements, the proposed European Centre providing a means of rectifying these shortcomings.

Commissioner Byrne presented a similar argument to the Network Committee, underscoring the high level of preparedness needed to combat communicable diseases, as demonstrated by SARS, and promoting the creation of a European Centre for Disease Prevention and Control as an effective means of strengthening Community activities.[312] At a meeting held from 9-10 April 2003, the Network Committee agreed to a set of immediate and future actions to address SARS and similar threats to public health in the long term. The document outlining the agreed future actions took note of the Commission's intention of proposing legislation on the establishment of a European centre, reiterating Commissioner Byrne's description of the intended role of the Centre given in his European Parliament address.[313] The Network Committee's recommendations for immediate and future actions were subsequently endorsed in the Council Conclusions from an extraordinary EPSCO Council meeting on SARS, held on 6 May 2003. The Conclusions took note of the Commission's intention to submit a proposal on the creation of a European centre for disease prevention and control and encouraged the Commission to 'consider developing a general preparedness plan on communicable diseases and health threats.'[314]

The Commission subsequently adopted the proposal for the regulation of the European Parliament and of the Council on the establishment of the ECDC on 16 September

[312] Rogers, 'Europe contemplates US-style disease-control centre', p. 1625.
[313] Communicable Disease Network Committee. *Future Actions.* 25 April 2003. Available from: http://ec.europa.eu/health/ph_threats/com/sars/sars_future_actions_en.pdf [Accessed on 31 March 2013], p. 3. See also 'European Centre is an important part of longer term response to SARS and similar threats', *Eurosurveillance* 7 (2003). Available from: http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=2219 [Accessed on 31 March 2013]; Communicable Disease Network Committee. *Immediate Actions*. Available from: http://ec.europa.eu/health/ph_threats/com/sars/sars_actions_en.pdf [Accessed on 31 March 2013].
[314] Council of the European Union. *Extraordinary Council Meeting – Employment, Social Policy, Health and Consumer Affairs.* 8954/03 (Presse 122). Brussels, 6 May 2003, p. 8.

2003. The aim of the ECDC, according to the Commission Proposal, was 'to provide a structured and systematic approach to the control of communicable diseases and other serious health threats, which affect European Union citizens.'[315] In addition to overseeing the operational instruments under Decision 2119/98/EC and surveillance networks in place to deal with specific diseases, the Centre 'would provide EU policy makers and citizens with authoritative and independent advice on serious health threats and recommend control measures for the Commission and national authorities' as well as 'issue scientific opinion on risk assessment on a wide spectrum of issues related to communicable diseases, such as clinical medicine, epidemiology, microbiology, and preventive measures.'[316] Article 3 of the Regulation establishing the Centre outlined the mission and tasks of the ECDC as follows:

> 1.In order to enhance the capacity of the Community and the Member States to protect human health through the prevention and control of human disease, the mission of the Centre shall be to identify, assess and communicate current and emerging threats to human health from communicable diseases. In the case of other outbreaks of illness of unknown origin which may spread within or to the Community, the Centre shall act on its own initiative until the source of the outbreak is known. In the case of an outbreak which clearly is not caused by a communicable disease, the Centre shall act only in cooperation with the competent authority upon request from that authority. In pursuing its mission the Centre shall take full account of the responsibilities of the Member States, the Commission and other Community agencies, and of the responsibilities of international organisations active within the field of public health, in order to ensure comprehensiveness, coherence and complementarity of action.
>
> 2.Within the field of its mission, the Centre shall:
>
> (a) search for, collect, collate, evaluate and disseminate relevant scientific and technical data;

[315]Commission of the European Communities, *Proposal for a Regulation Establishing a European Centre [for Disease Prevention and Control]*, p.2.
[316]Commission of the European Communities, *Proposal for a Regulation Establishing a European Centre [for Disease Prevention and Control]*, p.3.

(b) provide scientific opinions and scientific and technical assistance including training;

(c) provide timely information to the Commission, the Member States, Community agencies and international organisations active within the field of public health;

(d) coordinate the European networking of bodies operating in the fields within the Centre's mission, including networks arising from public health activities supported by the Commission and operating the dedicated surveillance networks; and

(e) exchange information, expertise and best practices, and facilitate the development and implementation of joint actions.

3.The Centre, the Commission and the Member States shall cooperate to promote effective coherence between their respective activities.[317]

The proposed Centre thus marked a shift from an intergovernmental approach to communicable disease surveillance at EU level to a more centralised one through the establishment of an independent agency charged with risk assessment for the Union.

As in the case for the push for increased coordination following the anthrax attacks in 2001, the rationale behind the establishment of the ECDC was based on the need to respond to what was framed in the Commission Proposal as a new threat – that of the emergence of a highly virulent communicable disease with the ability to spread rapidly.[318] This use of language is again significant as it is suggestive of an ideological shift in terms of the way in which communicable diseases are recognised as issues to be acted upon. The Commission Proposal for a regulation on the establishment of the ECDC described the nature of the threat as follows:

[317] *Regulation (EC) No 851/2004 of the European Parliament and of the Council of 21 April 2004 establishing a European centre for disease prevention and control*. OJ L 142, 30.4.2004.
[318] Commission of the European Communities, *Proposal for a Regulation Establishing a European Centre [for Disease Prevention and Control]*, pp. 3-4.

> Communicable disease has always been one of the major *threats* [emphasis added] to human health. What has changed in the past few years is the growing realisation that natural outbreaks of communicable disease can still threaten both technologically advanced regions of the world such as the European Union as much as developing regions of the world with little health infrastructures. The possibility exists that a communicable disease outbreak could be started deliberately ("bio-terrorism"). In our increasingly interconnected and global world, a disease outbreak in one country can be spread internationally in a matter of hours or days. This 'new threat' and the need for a comprehensive EU approach to it, was also identified in the security strategy paper that was presented by the High Representative for the CFSP, Javier Solana, to the Thessaloniki European Council ("A secure Europe in a better world").
>
> In controlling a disease outbreak, time is of the essence. Every day lost in identifying the threat, deciding on control measures and implementing them can result in the outbreak spreading further. These lost days can mean the difference between a small outbreak and a serious epidemic. If the disease or pathogen involved is particularly lethal, then delay may cost lives.[319]

The Commission Proposal continued by arguing that rapid reaction and coordinated response to health threats is 'critical' in the European Union where the lack of internal borders enables products and people to move freely and where a small outbreak in one locale could quickly develop into an international public health threat if adequate measures are not in place, thereby establishing urgency for action. Citing SARS as an illustration of the capacity of a communicable disease outbreak to threaten not just the public health sector, but also the EU economy, the Proposal reiterated the need to be able to take 'rapid and effective action against a disease outbreak' in order to reassure EU citizens and protect Member States' economies and public health.[320]

The Commission Proposal on the establishment of the ECDC thus displayed some of the hallmarks of a securitizing move. Communicable diseases were presented as a new type

[319] Commission of the European Communities, *Proposal for a Regulation Establishing a European Centre [for Disease Prevention and Control]*, p. 3.
[320] Commission of the European Communities, *Proposal for a Regulation Establishing a European Centre [for Disease Prevention and Control]*, p. 4.

of threat that could not only cost lives, but also damage economies if effective measures were not in place to rapidly identify and respond to an emerging disease threat; hence, the need to strengthen EU-level preparedness, the establishment of the ECDC providing one means of doing so. Urgency in this instance was not established in response to the imminence of a particular disease threat itself, but in the threat of its emergence. Immediate action is thus required to ensure that measures are in place to rapidly identify and contain an outbreak once it occurs.

The reference made to the European Security Strategy is significant in this regard as the Strategy constituted the first attempt at identifying a common and distinct European approach to security. While disease is not listed in the strategy as one of the five key threats facing Europe, reference is given at the beginning of the Strategy to the nexus between disease, poverty and security in developing countries and the possibility of communicable diseases to not only contribute to the breakdown of society, but to also spread rapidly and become global threats.[321] Moreover, the 2003 Strategy argued that the dynamic nature of 'new threats' required an approach to security premised on threat prevention rather than reaction, requiring a readiness to act before a crisis occurs – arguably what the Commission Proposal was alluding to.[322] In fact, in justifying the need for the ECDC, the Commission Proposal stated that '[t]he ability to respond to an international health threat is profoundly influenced by the extent to which relevant issues have been studied in advance, and

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[321] *A Secure Europe in a Better World: European Security Strategy*. Brussels, 12 December 2003. Available from: http://www.consilium.europa.eu/uedocs/cmsUpload/78367.pdf [Accessed on 31 March 2013], p. 2. Worth noting here is that the 2008 report on the implementation of the 2003 Security Strategy does make a claim to the threat posed by pandemics to development efforts in a section of the report that discusses the security-development nexus. See *Report on the Implementation of the European Security Strategy – Providing Security in a Changing World*. S407/08. Brussels, 11 December 2008.

[322] *A Secure Europe in a Better World*, p. 7.

whether preparedness plans are in place for coordinated action.'[323] In this capacity, and making reference to the threat of an influenza pandemic, the Proposal argued for the need to establish an EU-level preparedness plan that would complement preparedness planning activities underway at the WHO and would be coordinated through the ECDC.

The threat framing presented in the Commission Proposal echoed that of the World Health Assembly's Resolution on SARS, adopted on 28 May 2003. The WHA Resolution expressed deep concern 'that SARS, as the first severe infectious disease to emerge in the twenty-first century, poses a serious threat to global health security, the livelihood of populations, the functioning of health systems, and the stability and growth of economies,' acknowledging the need for both individual and collective action, including regional and global collaboration, in controlling SARS and other emerging and re-emerging infectious diseases.[324] However, while the potential impact of a viral outbreak is expressed in similar terms in both instances, significant to note is the expression of a distinctly European referent object in the case of the Commission Proposal. While the outbreak and spread of a virus is clearly stated to be a threat potentially global in scale, the lack of internal borders and the ease of movement within the EU are presented as adding a specific European dimension to the threat. An EU agency is thus needed to help coordinate efforts to protect 'the health and wellbeing of the European Union's citizens.'[325] The Proposal thus argued that the possibility of communicable disease emergence posed a threat to the EU specifically – a threat that required urgent coordinated action to counter. In this case, the

[323] Commission of the European Communities, *Proposal for a Regulation Establishing a European Centre [for Disease Prevention and Control]*, p. 5.
[324] World Health Assembly. *Severe acute respiratory syndrome (SARS)*. WHA56.29, 28 May 2003, p. 1.
[325] Commission of the European Communities, *Proposal for a Regulation Establishing a European Centre [for Disease Prevention and Control]*, p. 2.

proposed course of action to be taken was the establishment of an independent European Centre for the assessment of risks to the Union.

On 21 April 2004, the Parliament and the Council adopted Regulation (EC) No. 851/2004 legally establishing the ECDC. The Council and the Parliament passed the Regulation on its first reading, not only indicating that differences on details of the proposed Regulation amongst the Commission, the Council and the Parliament were relatively marginal, but also suggestive of the urgency attributed to the Resolution's passing.[326] The establishment of the ECDC thereby marked another step in an evolving process of securitization underway at EU level, creating a centralised agency charged with risk assessment of communicable disease in the Union. Greer has described the political significance of the ECDC as follows:

> It was an EU information agency that embodied, and gave more autonomy and organizational coherence to, a set of surveillance and capacity-building activities that were already taking place and were much in demand in the early 2000s, and that were furthermore justified by Article 152 of the Amsterdam Treaty, an unthreatening warrant for the EU to help member states with health policies. For member states worried about sovereignty, it looked like symbolic politics; for advocates of a centre, it could look like a major action. The salami had already been sliced earlier, leaving behind only the most politically attractive element: an agency that could be put forth as evidence of political responsiveness to a crisis....'[327]

[326] Greer, 'The European Centre for Disease Prevention and Control', p. 1010. At an EPSCO Council held from 1-2 December 2003, after extensive debate, a common general position on the proposed Regulation for a European Centre was established with the view of adopting the proposal in its first reading following the opinion of the European Parliament. Council of the European Union. *2549th Council Meeting – Employment, Social Policy, Health and Consumer Affairs*. 15443/03 (Presse 354). Brussels, 1-2 December 2003, p. 27. The Parliament adopted its position on 10 February 2004 following a report from John Bowis, the assigned Rapporteur, who urged a single reading on the proposal, expressing the urgent need to establish the Centre – a sentiment that was echoed by other MEPs in their comments during the plenary session. European Parliament. *Sitting of Tuesday, 10 February 2004*. Available from: http://www.europarl.europa.eu/RegData/seance_pleniere/compte_rendu/traduit/2004/02-10/P5_CRE(2004)02-10_DEF_EN.pdf [Accessed on 31 March 2013], p. 15.

[327] Greer, 'The European Centre for Disease Prevention and Control', p. 1009.

Although a relatively weak agency, lacking executive powers and having limited financial resources and in-house capacities, Greer has argued that the Centre has the potential to establish itself as a new source of European power on two fronts: First, by reinforcing communicable disease control as a recognised European problem requiring European solutions through ECDC activities over time; and second, by establishing itself as a hub for networks connected to various aspects of communicable disease control within the Union.[328] The creation of the ECDC thus constituted another step in the consolidation of communicable disease control within the Union.

By mid-2004, then, the threat of infectious disease emergence – either by deliberate or natural means – and the need to prepare for it had begun to take on salience at the level of the EU. Within this time period, infectious disease came to be framed not just as a risk to populations, but also as a threat to the health of European Union citizens and to Member States' economies, particularly as a result of the lack of internal borders in the Union. Moreover, the threat posed by communicable disease was constituted not just as a global challenge, but also as a distinctly European one. The SARS outbreak reinforced this perceived vulnerability and served as a galvanising event that was not only used by the Commission to advance its case for the establishment of the ECDC, but also provided an external contextual backdrop that lent support to the Commission's securitizing claims. The combination of the anthrax attacks in 2001 and the SARS outbreak in 2002-2003 thus set in motion a set of activities at EU level aimed at strengthening Union capacity to counter the

[328] Greer, 'The European Centre for Disease Prevention and Control', pp. 999-1000; 1016; 1021.

threat posed by the microbial world and provided a contextual backdrop that informed responses to the resurgence of the H5N1 avian influenza virus in 2004-2005.

The re-emergence of H5N1 and the push for further EU-level coordination on pandemic preparedness

The re-emergence of the avian influenza virus H5N1 followed rapidly on the heels of the experience with SARS and despite initial reports of avian-to-human infections in Hong Kong in 1997, it was the resurgence of the virus and its spread to the borderlands of Europe in 2004-2005 that triggered a flurry of activity around pandemic preparedness planning at the level of the EU. John Ryan, Head of the Health Threats Unit at the Directorate-General for Health and Consumers (DG SANCO) at the time of interview, described the impact of SARS and H5N1 on developments in the EU as follows:

> With the area of preparedness, I think if you look at the experience with avian flu and the threat that it was considered to pose, the concrete examples of SARS and the health and economic consequences of the SARS outbreak, I think impressed upon everyone the need to increase preparedness at the European level....The fact that the Union developed this planning mechanism for pandemic preparedness in 2005 is sort of a major stepping point....It's a major block of work which was done as a result of this pressure.[329]

The resurgence of the H5N1 influenza virus served as yet another crisis event that reinforced the need to strengthen capacities within the Union to address the threat of communicable disease emergence. Thus, as in the case with SARS, while the Commission

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[329] Ryan, J., Head of Health Threats Unit, DG SANCO, interview by author, 30 June 2011, Luxembourg, tape recording, DG SANCO, Luxembourg.

was already advocating for the strengthening of pandemic preparedness planning in the years leading up to the resurgence of H5N1, the events of 2004-2005 mobilised pandemic preparedness activities at Union level.

Worth raising here is the question as to whether pandemic preparedness planning can be considered a product of securitization. In discussing securitization in the environmental sector, Buzan, Wæver and de Wilde have argued that contingency planning is not necessarily a form of securitization in and of itself, although the execution of a contingency plan is: 'The preparation phase is like discussing the size and sources of a fire brigade, the police, or the army: It is an aspect of ordinary politics unless the allocation of resources is possible only with securitization. But once the fire, the riot, or the war breaks out, the contingency plan receives priority and replaces ordinary politics.'[330] The distinction made between planning and action in this instance, however, appears to contradict the Copenhagen School's claim that a successful securitization does not have to result in the implementation of emergency measures, but rather just provide the platform from which the legitimation of the implementation of such measures can be made.[331] Arguably the differentiation between planning and action is somewhat arbitrary since it is ultimately the ideational shift in thinking with which securitization theory is concerned.

On this point, this chapter argues that an ideational shift in thinking in terms of the manner in which pandemic influenza is recognised as an issue to be acted upon has in fact occurred, as evidenced by the shift in rhetoric throughout the time period under analysis and the concomitant mobilization of activities to confront the threat of a pandemic eventuality. Indeed, the mobilization around pandemic preparedness planning is arguably

[330] Buzan et al., *Security*, p. 83.
[331] See Buzan et al., *Security*, p. 25.

itself an indication of an ideational shift in thinking, marking a shift away from classic public health interventions to focus on what Lakoff has identified as vital systems security.[332] Lakoff and Collier describe the difference between classic public health interventions and preparedness as follows:

> In contrast to classic public health, preparedness does not draw on statistical records of past events. Rather, it employs imaginative techniques of enactment such as scenarios, exercises, and analytical models to simulate uncertain future threats. The aim of such techniques is not to manage known disease but to address vulnerabilities in health infrastructure by, for example, strengthening hospital surge capacity, stockpiling drugs, exercising response protocols, and vaccinating first responders. Approaches based on preparedness may not be guided by rigorous cost-benefit analysis. Rather, they are aimed at developing the capability to respond to various types of potentially catastrophic biological events.[333]

This logic of preparedness, according to Lakoff, has its origins in sovereign state security and civil defence.[334]

The three crisis events covered in this chapter have played an important role in marking this shift in ideational thinking by highlighting the threatening potential of communicable disease emergence and lending support to securitizing claims made. Indeed, prior to the initial identification of the H5N1 avian influenza virus in 1997, pandemic preparedness planning did not receive heightened attention at EU level. Since 1996, national governments had been funding the European Influenza Surveillance Scheme (EISS), a project that built on earlier surveillance networks in Europe and that was subsequently

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[332] For a more detailed description of vital systems security, see Lakoff, 'From Population to Vital System', pp.36-8.

[333] Collier, S. J. & A. Lakoff, 'The Problem of Securing Health', in *Biosecurity Interventions: Global Health and Security in Question*, edited by Andrew Lakoff & Stephen J. Collier (New York, Columbia University Press, 2008), p. 14.

[334] Lakoff, 'From Population to Vital System', p. 37.

funded by the European Commission from 1999 until 2006 before it was taken over by the ECDC.[335] The adoption of Decision 2119/98/EC in 1998 setting up the network for epidemiological surveillance and control of communicable diseases in the Union marked another landmark in communicable disease control within the Community at this time period. However, it was the identification of the H5N1 avian influenza virus in Hong Kong in 1997, along with the first documented cases of bird-to-human transmission that brought international attention specifically to the issue of pandemic preparedness planning. Of the 18 people initially infected with the virus, six died.

Weaknesses in the capacities of EU Member States to respond to an influenza pandemic were also made apparent in this time period. A scientific study undertaken in 1999 reviewed Europe's ability to cope with a series of outbreak events. Although not making any securitizing claims and therefore not explicitly engaged in the securitization of pandemic influenza, the study revealed that in the case of pandemic influenza in particular, a low level of preparedness existed across Member States.[336] That same year, the WHO published its first official guidance document on national and regional pandemic preparedness planning, the purpose of which was to provide guidelines for medical and public health leaders in responding to a pandemic influenza.[337] Drawing from the 1999 WHO

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[335] European Centre for Disease Prevention and Control. *About European Influenza Surveillance Network (EISN)*. Available from: http://ecdc.europa.eu/en/activities/surveillance/EISN/about_EISN/Pages/About_network.aspx [Accessed on 31 March 2013].

[336] McKee, Hervey & Gilmore, 'Public health policies', p. 252; MacLehose, L., H. Brand, I. Camaroni, N. Fulop, O. N. Gill, R. Reintjes, O. Schaefer, M. McKee & J. Weinberg. 'Communicable disease outbreaks involving more than one country: systems approach to evaluating the response', *British Medical Journal* 323(2001), pp. 861-3. In fact, of interest to note is that the study argued for the strengthening of existing surveillance networks in the Union, stating that the creation of a European centre for disease surveillance and control was not necessary. See, MacLehose et al., 'Communicable disease outbreaks involving more than one country', p. 863.

[337] Kamradt-Scott & McInnes, 'The securitisation of pandemic influenza', p. S103; World Health Organization. *Influenza pandemic plan. The role of WHO and guidelines for national and regional planning*. WHO/CDS/CSR/EDC/99.1 (Geneva, World Health Organization, 1999). The document was subsequently updated in 2005 in light of ongoing revisions to the International Health Regulations (IHR) and the lessons

guidelines, in November 2001, the Commission organized a conference in Brussels with the purpose of identifying and examining the existing measures in the EU that could be built upon in the creation of a European pandemic preparedness plan. The aim of the conference was to produce a set of recommendations targeted at 'European decision-makers, patient groups, corporate interests and the media' for strengthening Europe-wide coordination in addressing the threat of pandemic in Europe, with a particular focus on influenza.[338] Those in attendance included representatives from the Commission, the WHO, national health experts and Ministers, industry and the European Medicines Agency (EMA, formerly EMEA). The timing of the conference is worth noting as it occurred the month following the anthrax attacks in the United States in October 2001.

Commissioner Byrne opened the conference with an address in which he stressed the 'vital' need for pandemic preparedness planning, particularly given 'these anxious times when our lives have been overshadowed by biological terrorist threats.'[339] He continued by citing influenza as 'a classic example for pandemic challenge through aerial infection', asserting that 'a new influenza pandemic has to be anticipated in the foreseeable future' and that '[c]oordinated Community action is needed to address this threat.'[340] While not the official view of the Commission, the Preliminary Conclusions and Recommendations adopted by the conference participants reflected Commissioner Byrne's sentiments, stressing the need for Community-level action on the basis of the following argumentation:

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learned from the control of SARS in 2003. See World Health Organization. *WHO Global influenza plan: The role of WHO and recommendations for national measures before and during pandemics*. WHO/CDS/CSR/GIP/2005.5 (Geneva, World Health Organization, 2005).

[338] European Commission. *Introduction. Pandemic Planning in the Community: Influenza and other Health Threats*. Brussels, 27 November 2001. Available from: http://ec.europa.eu/health/ph_threats/com/Influenza/introduction_en.pdf [Accessed on 31 March 2013].

[339] Byrne, D. 'A clear need for pandemic preparedness plans on influenza', *Conference on Preparedness Planning in the Community – Influenza and other Health Threats.* SPEECH/01/583, Brussels, 27 November 2001.

[340] Byrne, 'A clear need for pandemic preparedness plans on influenza'.

> The next pandemic is imminent. EU Member States are not prepared. Vaccine availability is not secured. Antiviral stocks do not exist and will not be under the current market forces. In the event of a pandemic millions of people could die, economies will be affected and services (medical, civil) could collapse. Members of the public will not excuse authorities, who will be held responsible for not having put in place up-to-date preparedness.
>
> Therefore, a Community preparedness plan is needed which can be applied before a pandemic arises and immediately as it happens. All Member States have to complete and to implement national plans.[341]

The statement contained all the hallmarks of a securitizing move. The urgency for action is made clear. The threat is described as imminent, the potential consequences of inaction extending beyond possible morbidity and mortality rates to also include the possible undermining of economic, societal and ultimately political stability. Moreover, the statement leaves little room for negotiation. Member States must act and a Community preparedness plan needs to be put in place to mitigate the effects of a pandemic inevitability.

The parallels drawn between bioterrorism and pandemic influenza by Commissioner Byrne are significant to note, particularly given the framing of pandemic influenza as a threat to the EU in Commissioner Byrne's address – a framing that is also reflected in the Recommendations and Conclusions adopted at the Conference. Taken together, the responses to the 2001 anthrax attacks and the call for pandemic planning mark the beginnings of a shift in the way in which communicable disease is approached at Union level

[341] 'Preliminary Conclusions and Recommendations as proposed by the audience', *Pandemic Preparedness in the Community: Influenza and other Health Threats, Conference Brussels*. 27 November 2001. Available from: http://ec.europa.eu/health/ph_threats/com/Influenza/conclusion_en.pdf [Accessed on 31 March 2013].

and are thus significant moments in the process of securitizing pandemic influenza at the level of the EU.

It is against this background that the Commission produced its Working Document on pandemic preparedness planning in the Union, introduced on 26 March 2004. The timing of the document is significant in that it followed on the back of the experiences with SARS and coincided with a resurgence of the H5N1 virus in Asia. By the end of February 2004, outbreaks of the H5N1 influenza virus had been reported in poultry in China, Hong Kong, Korea, Thailand, Vietnam, Japan, Cambodia and Laos, while human cases of the virus were confirmed in Vietnam and Thailand. An investigation into a family cluster of H5N1 cases in Vietnam, moreover, was unable to rule out the possibility of limited human-to-human transmission.[342] These developments corresponded with a growing concern with the threat of pandemic influenza internationally, as expressed in such international fora as the WHO and the GHSI. In 2002, the GHSI expanded its mandate to encompass pandemic influenza and related issues of preparedness and response, while on 28 May 2003, the WHA adopted a Resolution on the prevention and control of influenza pandemics and annual epidemics. The Resolution expressed concern over 'the general lack of national and global preparedness for a future influenza pandemic, particularly in view of the recurrence of such pandemics and the high mortality, social disruption and economic costs that they invariably cause,' and urged Member States to develop and implement pandemic influenza preparedness plans.[343]

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[342] World Health Organization. *H5N1 avian influenza: Timeline of major events.* 25 January 2012. Available from: http://www.who.int/influenza/human_animal_interface/H5N1_avian_influenza_update.pdf [Accessed on 31 March 2013].
[343] World Health Assembly. *Prevention and control of influenza pandemics and annual epidemics.*WHA56.19, 28 May 2003.

In the lead-up to the release of the Commission's Working Document on pandemic preparedness, Commissioner Byrne, at an informal ministerial meeting of health ministers held on 12 February 2004, reasserted the inevitability of a pandemic influenza, referring to an influenza pandemic being 'a matter of when, not if [emphasis original]', before announcing the Commission's intention of adopting the Working Document as another key planning instrument in the EU alongside the already existing surveillance and response networks and the ECDC.[344] The purpose of the Working Document was to spur debate and recommendations on the coordination of influenza preparedness planning in the Union. The Working Document itself was prepared in consultation with the Network Committee, the WHO, and the EMA, and was reviewed by the Public Health Preparedness and Response Planning Group – a group created to advise the Commission on matters pertaining to public health emergencies.[345]

In addition to drawing upon the recommendations for Community-level action agreed upon at the 2001 conference, the Working Document outlined the key aspects of preparedness planning developed on the basis of the 1999 WHO guidelines on pandemic preparedness. Echoing previous justifications for action, the document argued for the need for pandemic preparedness planning on the basis of past experience that had demonstrated 'that the ability to respond to an international threat to health is profoundly influenced by the extent to which the issues have been considered in advance and plans are in place for co-ordinated action.'[346] The Working Document reiterated the 'severe public health and economic implications' that an influenza pandemic was likely to incur, making reference to

[344] Byrne, D. 'Avian influenza: Planning and coordination key weapons in tackling public health threats', *Informal Ministerial Meeting of EU Health Ministers*. SPEECH /04/74, Brussels, 12 February 2004.
[345] Commission of the European Communities. *Commission Working Document on Community Influenza Pandemic Preparedness and Response Planning*. COM (2004) 201 final. Brussels, 26.03.2004, p. 3.
[346] Commission of the European Communities, *Commission Working Document on Community Influenza Pandemic Preparedness and Response Planning*, p. 5.

the 1918 influenza pandemic that resulted in approximately 20 million deaths worldwide in stressing the urgent need to establish a Community influenza preparedness and response plan and noting that '[o]n average pandemics causing high morbidity and mortality have occurred every 25 years during the last century, whereas the last pandemic took place more than 30 years ago.'[347] In keeping with the arguments presented by Commissioner Byrne to the European Parliament and to the Network Committee on the establishment of the ECDC, the document also made a case for the ECDC on the basis of 'provid[ing] a structured and systematic approach to the surveillance and control of communicable diseases and other serious health threats that might affect the people of the European Union,' thereby strengthening the EU's response capabilities to public health emergencies more generally.[348]

The significance of the language in the Working Document is two-fold: First, in drawing on the securitizing move presented in the Conclusions and Recommendations from the 2001 pandemic preparedness conference as well as on previous calls for action that presented similar arguments concerning the disruptive capacity of communicable disease and the need to take preparatory action, the Working Document reinforced a particular securitizing logic that had begun to emerge within the Union in the years following the 2001 anthrax attacks. This securitizing logic is based on an urgency for action premised on the unpredictability, yet inevitability of a communicable disease outbreak and its capacity to not only threaten health, but also the critical functioning of the economy. The threat posed by communicable disease, moreover, is presented in this context as not only a distinctly contemporary one, facilitated by processes of globalization, but also a uniquely European

[347] Commission of the European Communities, *Commission Working Document on Community Influenza Pandemic Preparedness and Response Planning*, p. 4.
[348] Commission of the European Communities, *Commission Working Document on Community Influenza Pandemic Preparedness and Response Planning*, p. 27.

one due to the open borders within the Union. Second, the reference to the 1918 influenza pandemic points to the constitution of pandemic influenza as a distinct threat subject from that of emerging and resurgent infectious diseases (ERIDs) more broadly. The reference given to the cyclical nature of influenza pandemics and the suggestion that an influenza pandemic is overdue not only implies an urgent need to prepare for the next one, but also points to a threat subject that is and will remain recurring.

The Council took note of the Commission Working Document in the Council Conclusions on pandemic influenza, adopted at the EPSCO Council meeting on 1-2 June 2004. The Conclusions acknowledged the added value of pandemic preparedness planning at EU level and to this end, requested the Commission to extend the mandate of the Health Security Committee to cover pandemic preparedness and response planning. The Conclusions stated:

> THE COUNCIL OF THE EUROPEAN UNION:
>
> 1. RECOGNISES that while pandemic preparedness planning remains primarily a Member State competence, there is added value in addressing this issue at a European level.
>
> 2. NOTES the importance of ensuring an effective response and a high level of operational preparedness with regard to future pandemic outbreaks.
>
> ….
>
> 10. AGREES TO:
>
> - request the Commission and the health ministers to extend the mandate of the Health Security Committee to cover the area of Community influenza pandemic preparedness and response planning for a temporary transitional period of one year to the end of May 2005 and then to review its mandate once the European Centre for Disease Prevention and Control has become operational in order to, inter alia, assess the desirability or otherwise of any future collective negotiation process with the pharmaceutical industry for the development and purchase of vaccines and

> antivirals, taking into account the cost, storage, logistical and legal aspects of this area, with a view to potential cost savings, while fully respecting Member States' competence; and
>
> - review the area of pandemic preparedness planning and the work of the structures involved before May 2005.[349]

The Council Conclusions also called on Member States and the Commission to co-ordinate on, and work towards the interoperability of national preparedness plans as well as to work towards a joint evaluation exercise.[350] The Conclusions thus broadly lent support to the previous calls for strengthening pandemic preparedness at EU level as expressed by attendees at the 2001 Commission-organized conference and the Commission working paper on pandemic preparedness in the Community. By June 2004, then, the securityness of pandemic influenza appeared to be broadly acknowledged by members of the Council.

The H5N1 avian influenza virus continued to spread over the course of the following year. By March 2005, recurring outbreaks of H5N1 in poultry had been reported in China, Vietnam, Indonesia, Thailand, Cambodia and Laos. New cases of bird-to-human infection had also been identified in Vietnam, Thailand and Cambodia, with the first published case of probable secondary human transmission identified in Thailand. The mortality rate of those humans confirmed infected remained high.[351] Activities at EU level focused on strengthening preparedness and response capacities in the Union. From 2-3 March 2005, the European Commission, in conjunction with the WHO, held a joint workshop on pandemic influenza planning with the purpose of identifying gaps and assistance needs for WHO and EU Member States in developing their preparedness plans, and on 6 April 2005,

[349] Council of the European Union. *2586th Council Meeting: Employment, Social Policy, Health and Consumer Affairs.* 9507/04 (Presse 163). Luxembourg, 1-2 June 2004, pp. 29-30.
[350] Council of the European Union, *2586th Council Meeting*, pp. 29-30.
[351] World Health Organization, *H5N1 avian influenza: Timeline of major events.*

the Commission adopted a Proposal for a Regulation of the European Parliament and of the Council establishing the European Union Solidarity Fund.

The aim of the proposed Regulation was to enlarge the scope of the already existing European Union Solidarity Fund (EUSF) from natural disasters to encompass 'industrial/technological disasters, public health threats and acts of terrorism.'[352] The proposed Fund was designed to provide financial assistance to Member States suffering from damages from major disasters, determined on the one hand, by the direct damage caused by a disaster and on the other hand, by a new criterion based on political considerations. The Proposal stated:

> A new criterion based on political considerations is introduced which enables the Commission in duly justified and exceptional circumstances to declare a disaster situation as 'major' even if the quantitative criteria are not met. This will allow mobilisation of the Fund for crisis situations where physical damage is still, at the moment of decision, limited; such a possibility is more likely with terrorist attacks or major public health crises. This possibility will allow for grants to assist victims of terrorism or pay for emergency measures in the event of unforeseen health crises and thus make possible to help refinance the cost of drugs, medicines and medical equipment used during an emergency. This will be particularly important to help protect the EU in the case of pandemics, in particular in officially declared influenza pandemics. The three influenza pandemics of the last century (in 1918, 1957 and 1968) killed millions of people and caused widespread disruption to the countries affected. Effective protection will require widespread and rapid use of anti-viral

[352] Commission of the European Communities. *Proposal for a Regulation of the European Parliament and of the Council establishing the European Union Solidarity Fund*. COM(2005) 108 final. Brussels, 6.4.2005, p. 3. The original European Union Solidarity Fund was established following severe flooding in central Europe in 2002. The Fund could be mobilised primarily following 'a major natural disaster with serious repercussions on living conditions, then natural environment or the economy' and was designed 'to supplement public expenditure by the individual Member States for essential emergency operations. Commission of the European Communities. *Commission staff working document – Annex to the Proposal for a Regulation of the European Parliament and of the Council establishing the European Union Solidarity Fund – Impact Assessment*. SEC(2005) 447 final. Brussels, 6.4.2005. For the Council Regulation establishing the original Solidarity Fund, see Council of the European Union. *Council Regulation (EC) No 2012/2002 of 11 November 2002 establishing the European Union Solidarity Fund*. OJ L 311, 14.11.2002.

> drugs and vaccines. The EUSF could be used to help refinance the cost of these drugs.[353]

The proposed Regulation thus aimed to further enhance response capacities to a pandemic eventuality in the Union by providing financial assistance to Member States who apply for assistance and meet the qualification criteria, as determined by the Commission. While the European Parliament broadly lent support to the Commission Proposal, however, the Council ultimately failed to adopt a position on it.[354] The widening of the EU Solidarity Fund thereby constituted one instance where a proposed course of action to be taken at Union level could not find sufficient support amongst members of the Council.

By September 2005, the H5N1 virus was moving closer to Europe, identified in poultry in both Russia and Kazakhstan. Indonesia had also confirmed its first human cases, while research at this point indicated that the virus could be carried by migratory birds.[355] On 22 September 2005, Chief Medical Officers and Chief Veterinary Officers of the Member States met in Brussels to discuss avian influenza and influenza pandemic preparedness planning, the conclusions and recommendations of which called for Member States to intensify their work on updating and adapting their contingency and preparedness plans in coordination with each other and the Commission.[356]

[353] Commission of the European Communities, *Proposal for a Regulation establishing the European Union Solidarity Fund*, p. 3.
[354] The Proposal was subsequently withdrawn by the Commission on 2 June 2012.
[355] World Health Organization, *H5N1 avian influenza: Timeline of major events.*
[356] The conclusions and recommendations from the meeting called for 'separate but consistent and coordinated actions by veterinary and public health authorities, to ensure improved preventive measures and preparedness for crises management,' maintaining that the threat posed by H5N1 along with the risk of a global influenza pandemic more generally 'should induce the Member States to intensify the work to update and adapt their Avian Influenza plans and Pandemic preparedness plan, in coordination with the other Member States and the Commission.' 'Avian Influenza and Influenza Pandemic Preparedness Planning: Conclusions and recommendations', *Meeting of the Chief Medical Officers and Chief Veterinary Officers of the*

The activities underway at Union level corresponded with a continued concern with pandemic preparedness planning internationally. In September 2005, the UN System Influenza Coordination (UNSIC) was created to assist the UN in supporting national, regional and global efforts to address the threat posed by avian and human influenza.[357] On 23 May 2005, the WHA adopted a second resolution, expressing a 'growing concern that the evolving, unprecedented outbreak of H5N1 avian influenza in Asia represents a serious threat to human health' and urging Member States to implement preparedness plans.[358] Significantly, Resolution WHA58.3 adopting the revised International Health Regulations (IHR) was also passed at the meeting of the WHA in May 2005. The revised IHR provided a legally binding framework for both Member States and the WHO to follow in responding to a public health emergency of international concern, defined by the IHR as 'an extraordinary event which is determined, as provided in these Regulations: (i) to constitute a public health risk to other States through the international spread of disease and (ii) to potentially require a coordinated international response.'[359] While the revised IHR did not enter into force until 2007, a WHA Resolution passed on 26 May 2006 called upon Member States to voluntarily implement the IHR in light of the evolving avian influenza situation and the 'serious risk to human health' posed by the possible emergence of a pandemic virus.[360] These international developments provided an additional contextual force that lent support to the calls for enhanced pandemic preparedness and response capacities within the Union.

Member States. Brussels, 22 September 2005. Available from: http://ec.europa.eu/food/animal/diseases/controlmeasures/avian/avain_influenza_22092005.pdf [Accessed on 31 March 2013].

[357] United Nations Development Group. *UN System Influenza Coordination (UNSIC)*. Available from: http://www.undg.org/index.cfm?P=21 [Accessed on 4 March 2012].

[358] World Health Assembly. *Strengthening pandemic influenza preparedness and response*. WHA58.5, 23 May 2005.

[359] World Health Organization, *International Health Regulations (2005),* 2nd edition, p. 9.

[360] World Health Assembly. *Application of the International Health Regulations (2005)*. WHA59.2, 26 May 2006.

By mid-October 2005, the H5N1 avian influenza virus had arrived at the borderlands of Europe, cases of the virus confirmed in poultry in both Romania and Turkey. The General Affairs and External Relations Council convened an extraordinary meeting on 18 October 2005 to discuss the avian and pandemic influenza situation. The Council adopted Conclusions that 'recognised that avian and pandemic influenza are global threats and called for an international coordinated response.'[361] The Conclusions also 'recognised that this problem must be addressed simultaneously within the EU and at source.'[362] The Council Conclusions welcomed initiatives aimed at improving coordination at EU level, including the establishment of a Friends of the Presidency group in October, designed 'to provide a forum for improved co-ordination and the sharing of information at a strategic level between those EU-level mechanisms handling different strands of both pandemic and avian influenza issues in the EU as well as at their source.'[363]

On 21 October 2005, Croatia reported its first cases of H5N1 in migratory birds, while on 23 October, the UK reported the virus in a quarantined parrot.[364] From 20-21 October 2005, EU Health Ministers held an informal meeting in Hertfordshire, UK under the UK Presidency to discuss preparedness planning, while a second WHO-European Commission joint workshop on pandemic planning was held from 24-26 October with the objective of improving the planning for and management of a pandemic eventuality in Europe.[365] With the encroachment of the H5N1 avian influenza virus onto European territory, the European

[361] Council of the European Union. *Extraordinary Council Meeting General Affairs and External Relations: External Relations*. 13378/05 (Presse 267). Luxembourg, 18 October 2005, p. 7.
[362] Council of the European Union, *Extraordinary Council Meeting General Affairs and External Relations*, p. 7.
[363] Council of the European Union. *Information Note: Council conclusions on avian and pandemic influenza – Outcome of proceedings.* 13448/05, 18 October 2005, p. 2.
[364] World Health Organization, *H5N1 avian influenza: Timeline of major events.*
[365] World Health Organization. *Pandemic Influenza Preparedness Planning: Report on the second joint WHO/European Commission workshop, 24-26 October 2005* (Copenhagen: WHO Regional Office for Europe, 2005).

Parliament adopted a resolution on a strategy against pandemic influenza on 26 October 2005. The Resolution emphasized the 'extremely serious' nature of the warnings issued by the WHO and the ECDC of a possible influenza pandemic and urged Member States to ensure that emergency plans were in place to respond to a pandemic eventuality. The Resolution stated:

> *The European Parliament*,
>
> ...
>
> 1. Considers the warnings by the WHO and the European Centre for Disease Prevention and Control (ECDC) about a potential influenza pandemic to be extremely serious; points out that an outbreak in one Member State or in the EU's neighbouring areas would cause an immediate health threat to the whole European Union;
>
> 2. Urges the Member States to take all necessary steps to prevent recombination of H5N1 into a flu virus that can be transmitted from person to person; insists therefore that workers in and connected to the poultry sector be vaccinated as a matter of priority;
>
> ...
>
> 4. Urges the Council to come to an agreement on influenza preparedness plans which guarantees the commitment of all Member States; stresses that these plans should include advance purchase agreements to ensure adequate supplies of vaccines and antivirals to meet pandemic demand as well as antibiotics to treat secondary infections to do so without delay and to communicate them to the Commission; urges all Member States to update their plans according to the results of real-time simulations and the new WHO and ECDC recommendations and to communicate those updates to the Commission;
>
> 5. Calls on the Commission to strengthen its coordinating role in close collaboration with the ECDC and to support the efforts of Member States by offering technical advice for their preparedness planning; calls on the Commission to report regularly to the European Parliament on the state of play and the actual amounts of vaccines in stock...[366]

[366] European Parliament. *European Parliament resolution on the strategy against an influenza pandemic.* P6_TA(2005)0406. Strasbourg, 26 October 2005.

The Resolution also urged Member States to increase coverage of seasonal influenza vaccination in keeping with WHO recommendations and called for support to third countries affected by the avian influenza virus. Significantly, the Resolution also called on the Health Council 'to mandate the Commission to take emergency measures within 24 hours, should a flu pandemic reach the EU or bordering states, such as quarantine and disinfection measures at airports for flights from infected regions, and travel restrictions.'[367] The Resolution thus displayed elements of a securitizing move by both stressing the urgency for action due to the 'extremely serious' and 'imminent' nature of the threat and by urging Member States and the Council to take necessary action to confront it, including requesting the Council to grant the Commission the authority to take extraordinary measures.

On 7 November 2005, the Council adopted Conclusions on avian and pandemic influenza, reiterating that effective coordination between Member States remained 'essential' and expressing support for the work being done in collaboration with the Commission to develop a comprehensive pandemic plan. The Conclusions also took note of the Commission's intention of adopting both a Communication on influenza pandemic preparedness and response planning as an update on the working paper adopted in March 2004, and a Communication on strengthening generic preparedness planning in the Union.[368] Later that month, in keeping with the Council's earlier request, between 23 and 25

[367] European Parliament, *European Parliament resolution on the strategy against an influenza pandemic.*
[368] Council of the European Union. *2686th Council Meeting: General Affairs and External Relations: General Affairs.* 13621/05 (Presse 273). Brussels, 7 November 2005, pp. 9-10.

November 2005, an EU-wide simulation exercise on pandemic influenza, entitled 'Exercise Common Ground', was held to test the interoperability of national plans.[369]

The Commission subsequently adopted the anticipated Communications on pandemic- and generic preparedness planning on 28 November 2005. In keeping with the Working Document that preceded it, the Commission Communication on preparedness and response planning for pandemic influenza outlined a pandemic plan that broadly corresponded with the pandemic phases and recommendations for planning provided by the 1999 WHO guidelines, but tailored to an EU context. The Communication justified the rationale for pandemic planning by juxtaposing the potential impact of a sustained human-to-human transmission of the H5N1 virus, described as 'capable of causing millions of deaths and huge economic damage', with the three major influenza pandemics of the 20th century that have preceded it – the so-called Spanish flu of 1918-1920, the Asian flu of 1957-1958 and the Hong Kong flu of 1968-1969 – before arguing for the necessity of EU action to address a threat that is unpredictable, yet inevitable:

> Whilst it is impossible to predict next pandemic's onset, health, social and other essential services are likely to be under severe pressure from its outset. An influenza pandemic would result in a high level of public, political and media concern and will cause, throughout and beyond the pandemic period, widespread social and economic disruption. Anxiety, movement restrictions, constraints on public gatherings, distribution difficulties, great number of excess deaths are all likely to add to pressures and disruption to the society.
>
> Effects of the pandemic on societies are inevitable, but careful preparedness and response planning can contribute to mitigating the extent and impact….Planning for a pandemic is a complex matter as there is little knowledge of the likely impact: data are uncertain and lack common features….

[369] For a summary report of the exercise, see Health Protection Agency. *Exercise Common Ground*. 27 March 2006. Available from: http://ec.europa.eu/health/ph_threats/com/common.pdf [Accessed on 31 March 2013].

> It is primarily the responsibility of each Member State to take the measures best adapted to fight human influenza pandemics. However, no country can alone face the consequences of a pandemic. International cooperation is an absolute necessity if its impact is to be reduced.
>
> In the EU, where there are not internal borders, additional coordination measures are necessary. Hence the need for EU-level action.[370]

Once again, pandemic influenza was framed as a threat not only to public health, but also to the economy and societal stability. Moreover, the threat of pandemic influenza was presented as posing a unique challenge to the EU due to the Union's lack of internal borders, thereby requiring a coordinated EU-level response.

The accompanying Communication on strengthening generic preparedness planning for public health emergencies, created in response to the request from Health Ministers at the extraordinary Council meeting on SARS on 6 May 2003, situated the risk of an influenza pandemic within the context of the terrorist attacks in the United States in 2001 and the SARS epidemic in 2003. Both instances, it argued, prompted governments to 're-think public health defences against communicable diseases', whether deliberately released or naturally occurring. All three incidents were described as having raised awareness as to the need for enhanced and coordinated defences against public health emergencies, defined as 'dominated primarily by events related to pathogens transmitted from person to person or through unsafe food or products; or through animals and plants or by harm to individuals by the dispersion or action of biological, chemical or physical agents in the environment.'[371]

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[370] Commission of the European Communities. *Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions on Pandemic Influenza Preparedness and Response Planning in the European Community*. COM(2005) 607 final. Brussels, 28.11.2005. pp. 4-5.

[371] Commission of the European Communities. *Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions on*

Common to all such emergencies were the assets and resources needed to counter them as well as the consequence management aspects of emergency and contingency planning.[372]

The aim of the Communication, along with the technical guidance documents accompanying it, was thus to delineate the key components of generic preparedness planning: information management; communications; scientific advice; liaison and command and control structures; preparedness of the health sector; and preparedness in all other sectors and intersectorally. The Communication and technical guidance documents were meant to provide 'the backbone for developing core elements in national plans, addressing generically different types of health threats, whether anticipated (such as pandemic influenza) or unexpected (e.g. a SARS-like epidemic)', with the aim of 'improving the interoperability of such plans.'[373]

Taken together, the Communication on pandemic influenza preparedness and response planning and the Communication on generic preparedness planning point again to the constitution of pandemic influenza as a threat subject in its own right, but also as an example of a broader threat subject focused on the emergent potential of a highly virulent biological agent more generally, whether naturally occurring or deliberately released. Once again, urgency for action is not based on the physical presence of the disease itself, but rather on the threat of disease emergence, action required now if the effects of an outbreak are to be mitigated and contained. The notion of health security has also expanded in this

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strengthening coordination on generic preparedness planning for public health emergencies at EU level. COM(2005) 605 final. Brussels, 28.11.2005, pp. 3, 4.

[372] Commission of the European Communities, *on strengthening coordination on generic preparedness planning*, p. 4.

[373] Commission of the European Communities, *on strengthening coordination on generic preparedness planning*, p. 4.

context beyond the narrow focus on bioterrorism and CBRN threats to include diseases of emergent potential.

The adoption of the Commission Communications was followed by an EPSCO Council meeting on 9 December 2005 at which a policy debate was held on the health aspects of pandemic influenza. The debate focused on three issues: information sharing and coordinated communication to the public on pandemic influenza; the contribution of EU level action in preparing for a pandemic, specifically as it concerns research and development programmes; and other specific actions that could be of added value, including improving the production capacity of and access to antivirals and vaccines.[374] On this latter point, the Commission announced at the meeting its intention of producing a discussion paper on the possibility of an EU stockpile of antivirals.[375] The Presidency Conclusions summarizing the debate took note of the two Commission Communications on preparedness planning and agreed that increasing the production capacity of antivirals was an 'urgent priority'. The Conclusions noted that while the acquisition of antivirals was primarily the responsibility of Member States, additional action could be taken at EU level and that further consideration should be given to the added value of an EU strategic stockpile of antivirals.[376]

Continuing outbreaks of H5N1 in poultry in Ukraine and Turkey as well as the confirmation of the first two human cases of the H5N1 virus in Turkey in January 2006 spurred the convening of an Extraordinary Joint Meeting between the Health Security Committee, the Influenza Coordinators of the EU Member States, and Representatives of

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[374] Council of the European Union. 2699th Council Meeting: Employment, Social Policy, Health and Consumer Affairs. 15201/1/05 REV 1 (Presse 336). Brussels, 8-9 December 2005.

[375] Council of the European Union. *Human health aspects of pandemic flu – Presidency conclusions*. 15648/05. Brussels, 12 December 2005.

[376] Council of the European Union, *Human health aspects of pandemic flu – Presidency conclusions*.

the Member States on the Early Warning and Response System on 12 January 2006. The Conclusions adopted at the meeting expressed the 'concern and anxiety in Europe and elsewhere' caused by the 'continuing outbreaks of avian influenza in poultry and humans in Turkey' and provided an assessment of the H5N1 presence in Turkey and the actions in place at EU level to prevent avian influenza from spreading.[377] Between January and June 2006, the H5N1 virus continued to spread throughout the European region, confirmed in wild birds in Bulgaria, Greece, Italy, Slovenia, Germany, France, Austria, Bosnia-Herzegovina, Slovakia, Hungary, Serbia-Montenegro, Switzerland, Poland, Denmark, Sweden, the Czech Republic, the United Kingdom, and Ukraine.[378] The possibility of creating a European stockpile of antivirals was taken up again at an EPSCO Council meeting held from 1-2 June 2006 during another discussion on pandemic influenza preparedness planning. The European Commission introduced its concept paper on an EU strategic stockpile to the Health Ministers. However, much to the disappointment of Commissioner Kyprianou, members of the Council were unable to reach an agreement on the proposed measure. Consequently, the responsibility to build up antiviral stockpiles remained with the Member States.[379]

On 14 June 2006, the European Parliament passed another Resolution on pandemic influenza preparedness and response planning in the Community. The Resolution once again stressed the necessity of continued support for the activities of the ECDC and for the need for the Commission to play a strong coordinating role in pandemic preparedness activities in

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[377] European Commission Health and Consumer Protection Director-General. *Extraordinary joint Meeting of the Health Security Committee, the Influenza Coordinators of the EU Member States and the Representatives of the Member States on the Early Warning and Response System: Conclusions*. Luxembourg, 12/01/2006. Available from: http://ec.europa.eu/health/ph_threats/com/Influenza/influenza_key11_en.pdf [Accessed on 31 March 2013].

[378] World Health Organization, *H5N1 avian influenza: Timeline of major events.*

[379] 'Influenza: Commissioner Kyprianou regrets failure to agree on EU anti-viral stockpile'. IP/06/732. Brussels, 02 June 2006.

the EU as well as the need for strong political commitment from Member States on preparedness planning.[380] The Resolution also stressed the need for 'rapid and decisive action' to prevent the avian influenza from becoming a human pandemic, arguing for attention to be paid to developing vaccine and anti-viral production capacities in Member States and at EU level and for the continuation of pandemic influenza simulation exercises as a 'vital' aspect of testing the effectiveness of preparedness plans.[381] The Resolution welcomed the Commission proposal for a regulation establishing the Solidarity Fund and reiterated the need for the Commission to be granted the capacity to adopt extraordinary measures within 24 hours of an influenza pandemic. The Resolution also stressed that the Commission should be given the mandate to establish a Community stockpile as a means of addressing the differentiated capacities of Member States to acquire pandemic vaccines.[382]

Activities aimed at enhancing preparedness planning continued at EU level in the years leading up to the outbreak of pandemic influenza H1N1 in 2009. On 16 November 2006, following the Council request of 1-2 June 2004, the Commission adopted a Communication to the Council proposing the prolongation and extension of the Health Security Committee's mandate for the following three years to include pandemic influenza and to enlarge its scope 'until a general review of all the legal provisions and other arrangements in the area of health threats is carried out.'[383] The Council subsequently adopted Conclusions on 22 February 2007 endorsing the extension of the HSC's mandate to

[380] European Parliament. *European Parliament resolution on pandemic influenza preparedness and response planning in the European Community*. P6_TA(2006)0259. Strasbourg, 14 June 2006.
[381] European Parliament, *resolution on pandemic influenza preparedness and response planning in the European Community*.
[382] European Parliament, *resolution on pandemic influenza preparedness and response planning in the European Community*.
[383] Commission of the European Communities. *Communication from the Commission to the Council on transitional prolongation and extension of the mandate of the Health Security Committee in view of a future general revision of the structures dealing with health threats at EU level*. COM(2006) 699 final. Brussels, 16.11.2006, pp. 3-4.

cover both pandemic influenza and generic preparedness and response planning on the basis of the recognised need for enhanced coordination and communication sharing at European level. The Conclusions also requested the Commission to 'come forward as appropriate with a proposal for a long-term solution for the Community framework for health security taking into account the structures in all relevant sectors to ensure that work is taken forward in the most appropriate forums, avoiding duplication and supporting effective cross-sectoral collaboration.'[384]

From 3-5 September 2008, the French government in cooperation with the Commission and the ECDC held a seminar in Angers, France with the aim of identifying weaknesses in Member State preparedness plans and means of enhancing intersectoral preparedness at EU level, while from 7-8 October 2008 a second simulation exercise was held. The aim of this exercise, 'Exercise Aeolus', was to test cross-sectoral communication and collaboration at national and EU levels in the event of a rapidly evolving health threat.[385]

On 16 December 2008, the Council adopted Conclusions on health security. The Conclusions described the threat posed by the microbial world to health security in the Union in the following terms:

> THE COUNCIL OF THE EUROPEAN UNION:
>
> 1. NOTES that the intensification and globalisation of trade, the increase in European and international travel and climate change constitute factors that may contribute to

[384] Council of the European Union. *2786th Council Meeting Employment, Social Policy, Health and Consumer Affairs*. 6226/07 (Presse 23). Brussels, 22 February 2007, pp. 21-3.
[385] Health Protection Agency. *Exercise Aeolus Final Report*. 7 & 8 October 2008. Available from: http://ec.europa.eu/health/ph_threats/com/preparedness/docs/aeolus_frep_en.pdf [Accessed on 31 March 2013].

the spread of pathogens in the European Union (EU) or to pathogens not previously present becoming established in Europe;

2. RECALLS that in recent years there has been an increase in health alerts that could lead to major cross-border threats for the EU (severe acute respiratory syndrome, H5N1, multi-drug-resistant tuberculosis, Chikungunya, etc.);

3. NOTES the entry into force on 15 June 2007 of the International Health Regulations (IHR 2005), a legal tool for international public health protection, and EMPHASISES the desirability for the Member States of the EU of coordinating their individual response as far as compatible with their obligations and rights under that instrument;

....

8. EMPHASISES, in the field of pandemic influenza, the efforts to prepare made since 2005 by the Member States and the Commission with the support of the ECDC, but also the work still to be done, identified inter alia in the summary of proceedings of the EUROGRIPPE seminar held in Angers on 3, 4 and 5 September 2008, such as in particular:

– the need to maintain political mobilisation both to combat the epizootic and to prepare in individual countries to cope with a human influenza pandemic;

– the need to take into account the intersectoral dimension of the issue, i.e. the preparation for a pandemic in other sectors of society and of the economy and in particular the maintenance of essential services and the possible desirability of closing schools or the approach to border issues;

….

13. INVITES Member States and the Commission to:

– strengthen their coordination in facing public health emergencies of international concern within the EU, as defined in IHR 2005;[386]

The Conclusions invited the Commission to update the 2005 Communication on influenza pandemic preparedness to take into account the intersectoral dimension of preparedness planning and emphasized the need to continue to improve the functioning of the HSC, including giving consideration to its status in order to ensure ‘in the management of major

[386] Council of the European Union. *Council Conclusions on health security*. 2916th Employment, Social Policy, Health and Consumer Affairs Council meeting, Brussels, 16 December 2008, pp. 1-3.

cross-border scourges, speed and consistency in the action taken by Member States and the Commission.'[387] On this latter point, the Conclusions requested the Commission to present a Communication in 2010 proposing a long-term solution for the Community framework on health security along with providing the HSC with a legal basis and legislative initiative to adapt the status of the HSC to future challenges.

By the end of 2008, then, pandemic influenza had not only been recognised as a threat in its own right, but also as an example of a broader threat subject constituted by the emergent potential of communicable disease. That which is threatened is not just the health of the EU citizen, but also the economic and societal stability of the Union as a whole, the lack of internal borders making the Union particularly vulnerable to an outbreak if coordinated measures are not in place. The experiences derived from the anthrax attacks in 2001 and the outbreak and spread of SARS in 2002-2003, moreover, provided a contextual backdrop that lent additional support to the perceived securityness of a pandemic influenza, particularly with the resurgence of H5N1 in 2003-2005. Both events not only demonstrated the vulnerability of societies to communicable disease emergence, but also provided a set of securitizing discourses and practices upon which subsequent arguments and responses to the threat of pandemic influenza at EU level could be built. The Council request for a legislative proposal on a Community framework for health security marked a significant point in this securitization process as it indicated the recognised need for formalized arrangements at EU level to confront cross-border health threats, thereby giving legal weight to pandemic preparedness efforts within the Union.

[387] Council of the European Union, *Council Conclusions on Health Security*, pp. 4; 3.

However, while the period between 2001 and 2008 saw the mobilization of pandemic preparedness planning within the Union and a gradual growth of EU-level competences and activities in managing the threat of disease, disagreements as to the precise nature of EU engagement in specific instances points to a process of securitization that continues to be negotiated. Despite two requests from the European Parliament to the Council on the granting of emergency powers to the Commission in the event of an influenza pandemic reaching the borders of the EU, for example, the Council has not authorised the Commission to take such action. The failure to broaden the European Union Solidarity Fund to encompass health crises and the failure to establish an EU level stockpile on antivirals despite Commission and Parliament support in both instances are two additional cases in point. On the issue of stockpiling, Marco Liverani and Richard Coker have noted that despite the potential of an EU stockpile 'to redress the imbalances between member states and thus illustrate the added value of EU policy in promoting solidarity,' the Council was unable to reach an agreement on the issue – a reminder, according to Liverani and Coker, 'that the implementation of large-scale public health interventions at EU level is still very difficult given key differences in national needs, resources, policy prospects, and the lack of sufficient EU legal authority in health policy.'[388]

These discrepancies point to a tension at the heart of the process of securitization at EU level precisely between the recognised securityness of pandemic influenza and the collective willingness to act on the claim. Moreover, they underscore the point made in chapter one of this thesis that securitization is not a binary condition, but rather a process – a point made all the more apparent given the multinational nature of the EU. By the end of

[388] Liverani & Coker, 'Protecting Europe from Diseases', p. 926.

2008, then, while it is possible to identify a process of securitization underway at EU level with political effect, this process remained an ongoing one.

Conclusion

This chapter has sought to examine the process of securitizing pandemic influenza at EU level in the years leading up to the outbreak of the influenza A(H1N1) pandemic in 2009 in light of the theory of securitization outlined in chapter one of this thesis. The aim of the chapter has been to both introduce the relevant actors engaged in shaping securitizing dynamics at EU level and to account for securitizing moves and their outcomes. In so doing, the chapter has identified two features of the EU that hold bearing for the analysis of securitization processes at EU level. First, the constellation of actors engaged in shaping securitizing dynamics at EU level is both narrow and specialized. The decentralised and fragmented nature of the EU polity means that those actors primarily involved in shaping the health security agenda at the level of the EU are experts, bureaucrats and politicians from the field of public health.

The exclusivity of these actors has been made apparent not only in the case of the EU response to the 2001 anthrax attacks, where health experts were central in framing the risk of bioterrorism as a threat to public health, but also in the dominant role that this pool of actors has played in propelling the health security agenda forward at EU level, as demonstrated in the push for the establishment of the ECDC and for the enhancement and coordination of pandemic preparedness planning within the Union. Given the specificity of these actors and given the rules of interaction that shape the interrelation between the three EU institutions, the chapter has argued that a clear and hierarchical distinction

between actor and audience cannot be maintained. Rather than occupying a position subordinate to the securitizing actor, audience in this context is an empowered one and also carries the capacity to exercise agency.

As a result of the lack of a clear distinction between actor and audience, and as a result of the various decision-making processes that exist beyond the official statements from the three EU institutions, the chapter has argued that the force between a particular securitizing move, its reception and outcome is not necessarily unidirectional and often difficult to ascertain. Nevertheless, in line with the approach to securitization theory outlined in chapter one of this thesis, this chapter has argued that by examining patterns of securitizing rhetoric and practice over time, it is possible to identify a process of securitization underway at EU level with political effect. The European Commission has played a key role in this securitizing process, moreover, given the prominent position that it occupies as a policy entrepreneur in the Union. This prominent position has been exemplified not only in the role that the Commission has played in reopening the debate on the establishment of the ECDC, but also in the role that the Commission has played in instigating the push for strengthened and coordinated pandemic preparedness planning within the Union.

Second, given the Union's limited power and regulatory nature, the chapter has argued that a successful securitization is unlikely to be expressed by the breaking free of otherwise binding rules, but rather by the push for further EU-level competences and activities in governing the threat of disease. Crucially, however, the chapter has argued that this push for EU-level capacity is not only an expression of securitization in this distinct political setting, but is also reflective of the nature of pandemic influenza as a particular

threat subject. As a persistent and recurrent challenge that carries potential transnational consequences, the threat of pandemic influenza requires cross-border collaboration to mitigate, yet the cyclical nature of pandemic influenza means that while the securityness of the threat of pandemic may be recognised, the urgent need for action may not be acknowledged or necessarily sustained. The chapter has argued, therefore, that the success of a securitization is not based on the recognised securityness of the threat subject itself, but rather on the collective willingness to act at EU level on a securitizing claim. A key point of contention that arises in the securitization process is therefore to what extent and in what capacity EU-level intervention should be sought in managing the threat of pandemic.

On this point, while the chapter has demonstrated that the period leading up to the outbreak of the 2009 influenza A(H1N1) pandemic has resulted in the gradual expansion of Community competences and activities in assessing and managing the threat of microbial emergence, the chapter has also drawn attention to those instances where disagreement as to the precise nature of Community engagement can be noted. Throughout the period under analysis, the expansion of Community competences and activities has been expressed through the creation of new bodies at Union level charged with various aspects of risk assessment and management, such as the HSC and the ECDC, and through the mobilization of pandemic preparedness planning throughout the Union.

However, disagreements have also emerged on the issues of Community stockpiling, the granting of emergency powers to the Commission, and the expansion of the EU Solidarity Fund to encompass pandemic influenza. While the Commission has played a key role in propelling the securitization process forward at EU level and has generally received the support of the Parliament, agreements on the establishment of particular policies have

not always gained sufficient support in the Council. This not only highlights the difficulties of implementing major public health interventions at EU level, as suggested by Liverani and Coker, but also brings to the fore an inherent tension in the securitization process itself – namely between the recognised securityness of an issue and the collective willingness to act on a claim. At the heart of this tension lies the question as to what level the threat of pandemic influenza should ultimately be managed – a tension that is explored in more detail in the next chapter of this thesis.

The chapter has demonstrated, moreover, that the process of securitizing pandemic influenza at EU level has been crisis driven, spurred and propelled forward by three crisis events: the anthrax attacks in 2001; the outbreak of SARS in 2002-2003; and the resurgence and spread of the H5N1 avian influenza virus from 2003-2005. While the anthrax attacks and SARS underscored the threatening qualities of a highly pathogenic communicable disease outbreak and established a number of new activities at EU level to combat the threat of disease, thereby providing a contextual backdrop informing responses to the resurgence of H5N1, the resurgence of the H5N1 avian influenza virus in 2004-2005 brought to the fore the threat of a pandemic eventuality and the need to prepare for it.

Throughout this time period, it is possible to trace both the evolution of a health security agenda at Union level, marked by the gradual expansion of competences and activities at EU level in managing the threat of disease, and the development of pandemic influenza as a particular threat subject. That which is threatened is not just the health of EU citizens, but also the potential economic and political stability of the Union as a whole. The EU is also constituted a site of vulnerability in its own right as a result of its open internal borders, justifying the need for EU-level action. Pandemic influenza is recognised as not only

one example of the threat of disease emergence more generally, but also a distinct threat in its own right, given its cyclical nature and the potential damage an influenza pandemic could cause, as demonstrated by the major influenza pandemics throughout history, particularly 1918.

The anthrax attacks marked a key point in this securitization process as they introduced the term health security to the EU lexicon and coincided with the beginnings of an ideational shift in thinking. Health security in this instance was understood in relation to the threat of biological and chemical agents, but in practice expanded over time to also encompass pandemic influenza. The attacks also marked a shift in discourse to focus on what the Commission referred to as a 'new type of threat'. This threat language was evoked and elaborated upon in subsequent years, both with respect to the experiences with SARS and with respect to the threat of an influenza pandemic, an influenza pandemic in particular serving as an archetype for the threat of disease emergence more generally given its cyclical nature.

The chapter has thus argued that throughout the time period under analysis, it is possible to identify an ideational shift in thinking with respect to the identification of pandemic influenza as an issue to be acted upon. This shift has been informed both by the crisis events documented throughout this chapter and by the securitizing discourses and practices that have accompanied them. A key feature of this ideational shift has been the increased attention and activities focused on pandemic preparedness planning within the Union. The combination of securitizing rhetoric and the push for further EU-level competences and activities in addressing pandemic influenza and the threat of disease

emergence more generally points to a securitization process underway at EU level with political effect.

Chapter 4: The 2009 influenza A(H1N1) pandemic and the securitization process

Introduction

The previous chapter examined the process of securitizing pandemic influenza at EU level in the years leading up to the outbreak of the influenza A(H1N1) pandemic in 2009. The chapter argued that throughout the time period under analysis, it is possible to account for a process of securitization underway with political effect such that, by the end of 2008, the securityness of pandemic influenza was not only broadly acknowledged, but the need for the formalization of EU level activities aimed at countering the threat of pandemic was recognised as necessary in response. This chapter picks up from where the previous chapter left off by focusing specifically on the outbreak of the influenza A(H1N1) pandemic in 2009. The aim of the chapter is to examine the 2009 influenza pandemic in light of the process of securitization preceding it as a means of determining the impact of the 2009 A(H1N1) outbreak event on the securitization process and vice versa.

The 2009 influenza A(H1N1) pandemic is significant for the purposes of this thesis on two accounts: First, it constituted the first pandemic event to test preparedness and response planning efforts at EU level. As such, it serves as a test case for examining the consequences of the securitization process documented in the previous chapter on an outbreak event. Second, the 2009 influenza A(H1N1) pandemic proved to be milder than initially anticipated, raising a particular set of challenges for response efforts. These challenges concerned the assessment,

management and communication of threat. The relatively mild nature of the 2009 influenza A(H1N1) pandemic and the challenges in responding to it carried the potential to undermine securitizing efforts to date and thus brings to the fore the question as to the impact of the crisis-driven nature of the evolving health security agenda at EU level on sustained preparedness efforts at the level of the EU. The 2009 influenza A(H1N1) pandemic thus serves as an important event in evaluating the process of securitizing pandemic influenza at the level of the EU, as well as its relative success.

The chapter argues that despite the ultimately mild nature of the 2009 influenza A(H1N1) pandemic and the perceived overreaction to it, the outbreak event did not instigate a process of desecuritization as signalled by a move away from the recognised need to prepare for a pandemic eventuality at EU level, but rather reinforced the securitization process already underway. Throughout the pandemic period, EU actors continued to call for further coordination of preparedness and response activities at EU level and drew on the challenges posed by the 2009 pandemic response precisely as a means of bolstering the claims for further coordinated EU level action.

The chapter argues that the materiality of threat thus continued to play an important role in the securitization process. However, rather than affirm previous securitizing claims by demonstrating the potential devastating effects of an influenza pandemic, the ultimately mild nature of the 2009 pandemic outbreak became a test case for the next pandemic to come. Securitizing arguments presented by the Commission drew from the shortcomings in the 2009 pandemic response in

reaffirming precisely the importance of coordinated EU level action. The crisis event thereby served as a strategic means of advancing claims for a stronger Community response in combating cross-border threats to health independent of the threatening qualities of the event itself. The threat of pandemic influenza has thus provided a structural force for further cooperation and coordination at Union level.

The chapter begins by providing an overview of the key events leading up to and following the WHO declaration of a pandemic in 2009, and EU level responses to them. Next, attention turns to the review of lessons learned instigated by the 2009 pandemic experience as a means of analysing what bearing the influenza A(H1N1) pandemic event had on the process of securitizing pandemic influenza at Union level. The chapter concludes with a discussion of the implications of these findings for the securitization of pandemic influenza at the level of the EU.

The 2009 influenza A(H1N1) pandemic and the initial EU response

As documented in the previous chapter, the period between 2001 and the end of 2008 marked a heightened awareness amongst public health experts and politicians, both within the EU and internationally, as to the threat posed by a possible influenza pandemic. In the EU, following the resurgence and spread of the H5N1 avian influenza virus in 2004-2005, pandemic preparedness planning received particular attention, efforts by the Commission to test and strengthen the coordination of preparedness plans and cooperative arrangements across the Union continuing throughout the period up until the outbreak of the influenza A(H1N1) virus in 2009. The 2009 influenza A(H1N1) pandemic, then, not only served to test EU-level

preparedness to date, but also legitimized concerns – at least initially – as to the threat posed by a pandemic eventuality. While the 2009 pandemic ultimately proved to be milder than first envisaged, initial signs suggested that the virus was particularly aggressive. The rapid spread of the virus globally and the possibility of the virus mutating to become more severe in subsequent waves, moreover, kept public health experts and politicians both within the EU and internationally on alert in the months following the first wave of the virus.

The ultimately mild nature of the 2009 influenza A(H1N1) pandemic, however, coupled with the expectation of a more severe pandemic underpinning planning assumptions created challenges in pandemic response efforts in the Union. These challenges were not only logistical, but also concerned risk perception and the perceived legitimacy and proportionality of response efforts. Thus, while on the one hand, the securitizing process in the years leading up to the 2009 A(H1N1) influenza outbreak contributed to the relative success of pandemic response efforts in the Union to the extent that pandemic plans were largely in place to respond to the crisis, this same securitizing process – in particular, the in-built expectation of a more severe pandemic event – also created difficulties in responding to what was ultimately a relatively mild pandemic scenario.

The 2009 influenza pandemic event, moreover, brought to the fore the cracks in Community-led coordinated response efforts to date, thereby underscoring weaknesses in the securitization process itself. Nevertheless, despite these challenges, the 2009 influenza A(H1N1) pandemic resulted in a continued push for further EU level coordination by the Council, the Parliament and the Commission

alike, both throughout and beyond the duration of the pandemic. Rather than instigate a process of desecuritization, then, the 2009 pandemic served as another crisis event that lent additional support to securitizing processes and activities already underway at Union level, providing a structural force for further cooperation and coordination within the Union.

The first signs of a novel influenza virus with pandemic potential emerged in March and April 2009 following an outbreak of an influenza-like illness in Mexico, later identified as the influenza A(H1N1) virus. By 21 April 2009, the health department in Oaxaca, Mexico had confirmed two deaths by atypical pneumonia and on 23 April, the first cases of the A(H1N1) influenza virus were reported by Mexico to the WHO. On the same day, public health officials in the United States announced seven cases of the virus in California and Texas.[389] On 25 April, with the closure of public gathering spaces in Mexico City following hundreds of suspected cases in Mexico and with the identification of further cases in the United States, WHO Director-General Margaret Chan, following the advice of the WHO Emergency Committee under the International Health Regulations, declared a Public Health Emergency of International Concern (PHEIC). The PHEIC was declared on the basis of a new swine flu virus, transmitted from human to human, and with pandemic

[389] World Health Organization Regional Office for South-East Asia. *Chronology of Influenza A(H1N1)*. Available from: http://www.searo.who.int/LinkFiles/Influenza_A(H1N1)_Chronology_of_Influenza_A(H1N1).pdf [Accessed 27 August 2012], p. 1.

potential – the first declaration of its kind following the entering into force of the revised IHR in 2007.[390]

The identification of the influenza virus as an H1N1 strain caused international alarm as the 1918 influenza pandemic, known for predominately affecting the young and healthy and for causing high rates of morbidity and mortality, was also an H1N1 type strain. The relatively high cases of serious illness and death initially reported in Mexico, along with the fact that the 2009 A(H1N1) virus seemed to be disproportionately affecting the otherwise healthy and young suggested that the 2009 A(H1N1) virus had the potential to take on a similar form to that of the 1918 influenza H1N1 pandemic. In a situation update report by the WHO on 24 April, the WHO described the unfolding influenza situation as 'of high concern' due to the fact that there were 'human cases associated with an animal influenza virus, and because of the geographical spread of multiple community outbreaks, plus the somewhat unusual age groups affected.'[391]

While the number of deaths caused by the 2009 A(H1N1) virus ultimately remained relatively low, the rate at which the virus spread 'played a key role in the WHO decision to raise the pandemic alert level from 4 to 5, and later to 6.'[392] On 27 April 2009, following the declaration of a health emergency in the United States and 40 confirmed cases in the country, and with the first cases of the virus confirmed in

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[390] European Centre for Disease Prevention and Control. *The 2009 A(H1N1) pandemic in Europe: A review of the experience* (Stockholm, ECDC, 2010), p. 6; World Health Organization Regional Office for South-East Asia, *Chronology of Influenza A(H1N1)*, p. 2.

[391] World Health Organization. *Global Outbreak and Response (GAR): Influenza-like illness in the United States and Mexico*, 24 April 2009. Available from: http://www.who.int/csr/don/2009_04_24/en/index.html [Accessed 3 May 2013].

[392] Ricci, J. 'H1N1 Returns, Again: The Globalization, Re-Conceptualization and Vaccination of "Swine Flu"', *Global Health Governance* 3(2010), p. 6.

Spain and Scotland, the WHO raised its pandemic alert level to four, indicating a 'significant increase in risk of a pandemic.'[393] That day, then-European Commissioner for Health and Consumer Affairs, Androulla Vassiliou, made a public statement on the Commission's reaction to the A(H1N1) outbreak in which she stressed the need to remain 'extremely prudent in assessing the current situation,' before holding a briefing with the General Affairs and External Relations Council on the evolving A(H1N1) situation.[394] The Council agreed to hold an extraordinary session of the Employment, Social Policy, Health and Consumer Affairs (EPSCO) Council to assess the situation on 30 April.

By 29 April, California had declared a state of emergency and the virus had officially spread to nine countries. In addition to the United States and Mexico, laboratory confirmed cases were reported in Germany, Austria, Canada, Israel, New Zealand, the United Kingdom and Spain.[395] The speed with which the A(H1N1) virus reached the EU was thus considerably faster than in the case of the avian influenza H5N1 virus in 2004-2005. The WHO raised the pandemic alert to level five and discussions between the European Commission, the European Medicines Agency and

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[393] World Health Organization Regional Office for South-East Asia, *Chronology of Influenza A(H1N1)*, p. 2; World Health Organization. *Global Alert and Response (GAR): Swine influenza – update 3*. 27 April 2009. Available from: http://www.who.int/csr/don/2009_04_27/en/index.html [Accessed on 3 May 2013].

[394] Vassiliou, A. *Statement by Androulla Vassiliou, EU Health Commissioner for Health on the EC's reaction to the novel flu virus outbreak in Mexico.* SPEECH/09/200, Brussels, 27 April 2009; Council of the European Union. *2938th Council Meeting General Affairs and External Relations*. 9097/09 (Presse 97). Luxembourg, 27 April 2009.

[395] World Health Organization. *Global Alert and Response (GAR): Influenza A(H1N1) – update 5.* 29 April 2009. Available from: http://www.who.int/csr/don/2009_04_29/en/index.html [Accessed on 3 May 2013].

the European vaccine manufacturers began that day on the development and production of vaccines.[396]

As anticipated, the Health Ministers of the Council held an extraordinary meeting on 30 April to discuss the unfolding events. By this time 257 cases of the A(H1N1) virus had been officially reported in 11 countries.[397] The Council Conclusions adopted at the meeting called for 'continued cooperation at the EU and international level' in responding to 'the threat of a possible but still uncertain pandemic outbreak.'[398] The Conclusions acknowledged the potential global threat posed by an outbreak like the influenza A(H1N1) virus, particularly given the increased frequency of international travel, and called for continued cooperation between Member States and the Commission, under the guidance of the WHO, as a means of enhancing national response measures to the virus. This included calling on the Commission to continue to facilitate information sharing and cooperation between Member States, 'in particular on risk evaluation, risk management and medical countermeasures to the A/H1N1 virus within the EU' and to 'promote the funding of measures for cooperation between the Member States on preparing for and responding to a health threat under the existing Community programmes and activities.'[399] On the same day, the Commission adopted Decision 2009/363/EC amending Decision 2002/253/EC under Decision No 2119/98/EC to include a specific

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[396] European Centre for Disease Prevention and Control. *European 2009 Influenza Pandemic Timeline*. 11 August 2010. Available from: http://www.ecdc.europa.eu/en/healthtopics/H1N1/Documents/110810_2009_pandemic_European_Timeline.pdf [Accessed 30 August 2012].
[397] World Health Organization. *Global Alert and Response (GAR): Influenza A(H1N1) – update 6.* 30 April 2009. Available from: http://www.who.int/csr/don/2009_04_30_a/en/index.html [Accessed on 3 May 2013].
[398] Council of the European Union. *Council Conclusions on Influenza A/H1N1 infection.* Employment, Social Policy, Health and Consumer Affairs Council meeting, Luxembourg, 30 April 2009, p. 1.
[399] Council of the European Union, *Council Conclusions on Influenza A/H1N1 infection,* pp. 2-3.

case definition for the novel influenza virus that had been reported in North America and that was now beginning to make an appearance in Member States.[400]

The virus continued to spread throughout the month of May and Dr. Margaret Chan, Director-General of the WHO, continued to stress the need for sustained international vigilance. In a speech given to the UN General Assembly on 4 May 2009, Dr. Chan warned that the influenza A(H1N1) pandemic remained unpredictable, suggesting that while the first phase of the 2009 A(H1N1) virus may have proved milder than initially envisaged, additional waves of the virus could be more severe:

> Historically, influenza pandemics have encircled the globe in two, sometimes three, waves. During the previous century, the 1918 pandemic, the most deadly of them all, began in a mild wave and then returned in a far more deadly one. In fact, the first wave was so mild that its significance as a warning signal was missed.
>
> As we are seeing, the world today is much more alert to such warning signals and much better prepared to respond.

[400] *Commission Decision of 30 April 2009 amending Decision 2002/253/EC laying down case definitions for reporting communicable diseases to the Community network under Decision No 2119/98/EC of the European Parliament and of the Council (2009/363/EC)* OJ L 110/58, 1.5.2009. This Decision was subsequently amended on 10 July 2009 to classify the influenza H1N1 virus as one of pandemic potential and preventable by vaccination. See *Commission Decision of 10 July 2009 amending Decision 2000/96/EC on communicable diseases to be progressively covered by the Community Network under Decision No 2119/98/EC of the European Parliament and of the Council (2009/539/EC)*, OJ L 180/22, 11.7.2009. The Commission also adopted Decision 2009/540/EC on 10 July 2009, amending Decision 2002/253/EC on the issue of case definitions for reporting Influenza A(H1N1) to the Community network in order to align the case definition of the novel influenza virus with the official definition provided by the WHO as well as Decision 2009/547/EC amending Decision 200/57/EC under Decision No 2119/98/EC to ensure that safeguards were in place to protect personal data communicated through the Early Warning and Response System (EWRS) for the purposes of contact tracing activities. See *Commission Decision of 10 July 2009 amending Decision 2002/253/EC as regards case definitions for reporting Influenza A(H1N1) to the Community network (2009/540/EC),* OJ L 180/24, 11.7.2009 and *Commission Decision of 10 July 2009 amending Decision 2000/57/EC on the early warning and response system for the prevention and control of communicable diseases under Decision No 2119/98/EC of the European Parliament and of the Council (2009/547/EC),* OJ L 181/57, 14.7.2009.

> The pandemic of 1957 began with a mild phase followed, in several countries, by a second wave with higher fatality. The pandemic of 1968 remained, in most countries, comparatively mild in both its first and second waves.
>
> At this point, we have no indication that we are facing a situation similar to that seen in 1918. As I must stress repeatedly, this situation can change, not because we are overestimating or underestimating the situation, but simply because influenza viruses are constantly changing in unpredictable ways.
>
> The only thing that can be said with certainty about influenza viruses is that they are entirely unpredictable. No one can say, right now, how the pandemic will evolve.[401]

While the 2009 influenza A(H1N1) virus looked at this point to be milder than initially anticipated, the continued spread of the virus internationally along with uncertainties as to how the virus would continue to evolve over time meant that the 2009 A(H1N1) virus remained cause for concern. By 1 June 2009, 62 countries had officially reported 17 410 cases of the A(H1N1) virus, including 115 deaths.[402] By 8 June, when EU Member State Ministers of Health convened for a two-day meeting to discuss vaccination strategies against the influenza pandemic, authorising the Health Security Committee to work further on the issue of vaccination, the number of confirmed cases had risen to 25 288 in 73 countries, including 139 deaths.[403]

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[401] Chan, M. 'H1N1 influenza situation', Statement made at the Secretary-General's briefing to the United Nations General Assembly on the H1N1 influenza via videoconference. Geneva, Switzerland, 4 May 2009. Available from: http://www.who.int/dg/speeches/2009/influenza_a_h1n1_situation_20090504/en/index.html [Accessed on 1 September 2013].

[402] World Health Organization. *Global Alert and Response (GAR): Influenza A(H1N1) – update 42*. 1 June 2009. Available from: http://www.who.int/csr/don/2009_06_01a/en/index.html [Accessed on 3 May 2013].

[403] Commission of the European Communities. *Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions: Pandemic (H1N1) 2009.* COM(2009) 481 final. Brussels, 15.9.2009, p. 4; Council of the European Union. *2947th Council Meeting: Employment, Social Policy, Health and Consumer Affairs.* 9721/2/09 REV 2 (Presse 124). Luxembourg, 8-9 June 2009, p. 19; World Health Organization. *Global Alert and Response (GAR): Influenza A(H1N1) – update 45*. 8 June 2009. Available from: http://www.who.int/csr/don/2009_06_08/en/index.html [Accessed on 1 September 2013].

On 11 June 2009, with the spread of the influenza A(H1N1) virus globally, 28 774 cases having been confirmed in 74 countries, the WHO raised the pandemic alert to level six, officially declaring the beginning of the pandemic phase of H1N1.[404] The ECDC endorsed the WHO's declaration, stating that 'raising the pandemic alert level to phase 6 is an appropriate decision due to the evolution of the influenza A(H1N1)v situation.'[405] While the pandemic was recognised by the WHO at this point as being of 'moderate severity', the WHO declaration of pandemic was significant for developments within the EU as it triggered the EU pharmaceutical legislation that enabled the fast-track authorization of pandemic vaccines and antivirals.[406] On 12 June 2009, the EMA launched its pandemic crisis management plan, enabling 'the accelerated assessment of influenza vaccines and antivirals, as well as their intensive safety monitoring when used during a pandemic.'[407] A number of Member States that had negotiated advance purchase agreements with the pharmaceutical industry also linked the activation of their contracts to the declaration of level six.

The official declaration of the pandemic phase of the 2009 A(H1N1) virus, however, combined with the relatively mild nature of the pandemic itself, created

[404] World Health Organization Regional Office for South-East Asia, *Chronology of Influenza A(H1N1)*, p. 8; World Health Organization. *Global Outbreak and Response (GAR): Influenza A(H1N1) – update 47*. 11 June 2009. Available from: http://www.who.int/csr/don/2009_06_11/en/index.html [Accessed on 1 September 2013].

[405] European Centre of Disease Prevention and Control. *ECDC agrees with WHO's announcement of raising pandemic alert level to phase 6*. 11 June 2009. Available from: http://ecdc.europa.eu/en/press/news/Lists/News/ECDC_DispForm.aspx?List=32e43ee8-e230-4424-a783-85742124029a&ID=268&RootFolder=%2Fen%2Fpress%2Fnews%2FLists%2FNews [Accessed 31 August 2012].

[406] Chan, M. 'World now at the start of 2009 influenza pandemic', statement to the press by WHO Director-General Dr. Margaret Chan, 11 June 2009. Available from: http://www.who.int/mediacentre/news/statements/2009/h1n1_pandemic_phase6_20090611/en/index.html [Accessed 19 September 2012].

[407] European Medicines Agency. *WHO declares influenza pandemic – European Medicines Agency initiates crisis-management plan*, Press release, 12/06/2009. Available from: http://www.emea.europa.eu/ema/index.jsp?curl=pages/news_and_events/news/2009/11/news_detail_000079.jsp&mid=WC0b01ac058004d5c1 [Accessed 31 August 2012].

logistical challenges in pandemic response efforts in the Union, made most apparent by the uneven access to medical countermeasures amongst EU Member States. While the declaration of level six spurred the fast-track authorization of vaccines and antivirals in the EU, once the production of these medical countermeasures had been activated, any reversal or scaling down of production was difficult to achieve. Thus, despite the recognition that the 2009 A(H1N1) influenza virus was likely to be a mild disease for most people, a number of Member States with advance purchase agreements were unable to alter the terms of their contracts with the pharmaceutical industry to reduce the amount of vaccines purchased.

Conversely, a number of Member States without advance purchase agreements experienced difficulties in acquiring medical countermeasures for their populations. John Ryan, then-Head of the Health Threats Unit at DG SANCO, described the situation as follows:

> [O]nce you trigger [the EU fast-track authorization] mechanism, it's very difficult to step that downwards. And it's also very difficult to manage a situation like that because you don't really know whether the virus is going to mutate or whether it's going to get worse. It can start off by being a very mild virus and then when it mutates it can become very dangerous.'[408]

The problems surrounding the acquisition of medical countermeasures were further compounded by the differentiated and sometimes contradictory approaches of Member States to their vaccination strategies. While some Member States decided

[408] Ryan, J., Head of Health Threats Unit, DG SANCO, interview by author, 30 June 2011, Luxembourg, tape recording, DG SANCO, Luxembourg.

to buy enough vaccines to cover their entire populations, other Member States had a vaccination strategy aimed at only covering a proportion of their populations, while still other Member States decided not to vaccinate at all. These contradictory approaches, along with the refusal of some medical doctors to endorse the need for vaccination, raised uncertainties amongst members of the population as to the need for vaccination and created challenges in risk communication.

These differentiated Member State responses to the pandemic underscored the limitations and inherent weaknesses of EU-wide coordination itself and of the authority exercised by such EU bodies as the ECDC in managing the pandemic. The contention surrounding the purchase and distribution of medical countermeasures highlighted what Greer has identified as the limited influence of the ECDC and the EU as a whole in managing the pandemic situation – a testament, according to Greer, 'to the ECDC's youth as well as the limits that have been set on it.'[409] In a similar vein, Marco Liverani and Richard Coker have pointed out that despite the evidence-based advice issued from the ECDC on the recommended move from strategies of containment to strategies of mitigation during the pandemic, the majority of Member States did not heed this advice, but rather continued with strategies of containment for months following the recommendation.[410] While, as Liverani and Coker have argued, the reasons for Member States' decisions may be varied, the response to the 2009 influenza A(H1N1) pandemic nevertheless

[409] Greer, 'The European Centre for Disease Prevention and Control', pp. 1000-1.
[410] Liverani & Coker, 'Protecting Europe from Diseases', p. 925.

underscored an inherent fragility to EU-led coordination to date and thereby to the securitization process itself.[411]

Despite these challenges, however, rather than instigate a process of desecuritization, the 2009 influenza A(H1N1) pandemic resulted in a continued push for further EU level coordination by all three EU institutions. The 2009 pandemic thus served as another crisis event that lent additional support to securitizing processes and activities already underway at Union level. Despite the ultimately mild nature of the 2009 influenza A(H1N1) pandemic, the crisis event itself still provided a strategic means of advancing arguments for the further consolidation of EU-level arrangements aimed at combating the threat of disease.

The challenges in responding to the A(H1N1) pandemic thus spurred the Council to push for further EU-level coordination, in particular on the issues of risk communication and vaccine acquisition. At the beginning of July, the Council, under the Swedish Presidency, held a series of expert and informal meetings to discuss unfolding events. On 1-2 July, an expert and informal ministerial meeting was held in Jönkjöping, Sweden with the aim of drawing up another set of Council Conclusions on the 2009 A(H1N1) pandemic. This was followed by an additional meeting of technical experts from 4-5 July and subsequently, an informal Health Council meeting from 6-7 July in which preparedness and response efforts to the pandemic were discussed and consensus sought on the joint procurement of vaccines against the A(H1N1) virus on the basis of a Commission information note on vaccination

[411] Liverani & Coker, 'Protecting Europe from Diseases', p. 925.

policy.[412] The meeting culminated with the Swedish Presidency requesting the Commission to set up a mechanism to assist with the joint procurement of vaccines for interested Member States.[413]

Following the Council request, the Commission produced a Communication to the European Parliament, the Council, the Economic and Social Committee, and the Committee of the Regions on Pandemic (H1N1) 2009 on 15 September 2009. The purpose of the Communication was to present the EU strategy on the 2009 influenza A(H1N1) pandemic to date, outlining 'the key issues on the public health coordination on pandemic (H1N1) 2009 at the EU level and internationally' as well as 'to highlight the important cross-sectoral dimension of the pandemic.'[414] At the request of the Council, five Commission Staff Working Documents covering vaccine development, vaccination strategies, joint procurement, communication to the public, and support to third countries respectively, accompanied the Communication. Of note is the explicit reference to the security implications of the pandemic in the Communication:

> The diffusion of the pandemic (H1N1) 2009 may have important implications on global, regional and national security, stability and governance. In this respect an EU policy aimed at strengthening 'early warning' capacity in third countries should be seen as a major component of the overall EU Security Strategy and a major contribution to better world stability and governance.[415]

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[412] Commission of the European Communities, *Pandemic H1N1 (200*9), p. 4.
[413] Commission of the European Communities, *Pandemic H1N1 (2009),* p. 9.
[414] Commission of the European Communities, *Pandemic H1N1 (2009),* p. 2.
[415] Commission of the European Communities, *Pandemic H1N1 (2009),* p. 9.

The Communication thus directly linked pandemic preparedness with the EU's Common Foreign and Security Policy.[416]

Addressing the internal dimension of pandemic preparedness and response, the Communication argued for the need to enhance EU-level cooperation in confronting the challenges posed by the threat of pandemic on the basis of the cross-border nature of the threat and the differentiated capacity of Member States to respond to it. The Communication stated:

> A global pandemic is a cross-border health threat which affects not only public health but also society and economies within the EU. However, the technical capacity, budgetary resources and preparedness structures are not equivalent and equally available in every Member State.
>
> Consequently, a coordinated and supportive EU-level approach to public health measures between the EU Member States can provide substantial benefits. Firstly, Member States can draw on the scientific advice and guidance of the European Centre for Disease Prevention and Control, thereby ensuring that national resources for scientific assessments are allocated more efficiently.
>
> Secondly, coherent and agreed approaches between Member States authorities on issues such as travel advice or school closures contribute to a better public understanding and trust in public health measures. Thirdly, Europeans demand information on pandemic situation [*sic*] and how to protect themselves. Good, objective, up-to-date communication with the

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[416] The link between global health threats and the EU's Common Foreign and Security Policy (CFSP) was made explicit once again in a Commission Communication on the EU's role in global health, produced on 31 March 2010. The Communication stated that the CFSP should play a key role in promoting the importance of access to health services 'in fragile contexts, humanitarian crisis and in peace and stabilization processes,' while arguing for the need to 'contribute to the global and third countries' national capacities of early prediction, detection and response to global health threats, under the International Health Regulations.' The purpose of the Communication was to outline an 'EU vision on global health' and to identify the guiding principles and areas for effective EU action in this domain. Commission of the European Communities, *The EU Role in Global Health*, p. 8. The Foreign Affairs Council responded to the Communication on 10 May 2010 in the form of Council Conclusions that welcomed an EU role in confronting global health challenges, albeit without being explicit about what precisely this role should entail. Council of the European Union. *Council Conclusions on the EU role in Global Health*. 3011th Foreign Affairs Council meeting, Brussels, 10 May 2010.

> public and the media means no mixed or wrong messages between countries.[417]

The potential immediate and long-term economic effects of a pandemic were elaborated upon in the Communication to include the possible multisectoral effects of a severe pandemic and the negative impact that it could have on the cross-border mobility of people and goods within the Union.[418]

The Communication thus built upon previous securitizing arguments concerning the cross-border nature of the threat and its potential impact on the economy and societal stability, while touching upon some of the weaknesses in coordination brought out by the 2009 influenza A(H1N1) pandemic before outlining what it identified as the 'key strategic strands' in countering the pandemic – namely, vaccine development, vaccination strategies, joint procurement, communication to the public, and support to third countries. Potential actions to be taken in each of these strands were outlined in the respective Working Documents accompanying the Communication. The Communication also made note of the Commission proposal to enlarge the scope of the EU Solidarity Fund to encompass public health crises pending before the Council since 2005 and urged the Council to consider how to move forward on this issue.[419]

The Commission Communication on Pandemic (H1N1) 2009 and the Working Documents accompanying it provided the basis for discussions at an extraordinary Council meeting of Health Ministers, held on 12 October 2009. On the basis of the

[417] Commission of the European Communities, 'Pandemic H1N1 (2009)', p. 3.
[418] Commission of the European Communities, 'Pandemic H1N1 (2009)', pp. 8-9.
[419] Commission of the European Communities, 'Pandemic H1N1 (2009)', p. 7.

Commission documents and of the previous Council activities centred on the pandemic in July, the Council adopted Conclusions on the 2009 A(H1N1) pandemic that identified a number of issues that the Council maintained should be part of a coordinated EU approach towards the pandemic. These broadly corresponded with the areas covered in the five Commission Working Documents and concerned the availability of vaccines, vaccination strategy, the regulatory process for vaccines, information and communication to the public, global cooperation, and multisectoral issues.[420]

The Conclusions took note of the Commission Communication on Pandemic (H1N1) 2009 'as an important contribution to the ongoing pandemic response' and invited the Commission to continue with efforts to make vaccines available and to strengthen the regulatory process on vaccine authorization. The Conclusions also invited the Commission to continue to facilitate common approaches to information and communication to the public, and to work on strengthening aspects related to the multisectoral dimensions of a pandemic, including updating the 2005 Commission Communication on pandemic preparedness and response planning in the Community – a request first made by the Council in 2008.[421]

In keeping with efforts to broaden access to vaccines within the Union, on 23 July 2009, the Commission presented the Council with a Proposal for a Recommendation on seasonal influenza. The proposed Recommendation drew from a 2003 World Health Assembly Resolution that sought to increase influenza

[420] Council of the European Union. *Council Conclusions on Pandemic (H1N1) 2009 – a strategic approach*. 2965th Employment, Social Policy, Health and Consumer Affairs Council Meeting, Luxembourg, 12 October 2009, pp. 4-5.
[421] Council of the European Union, *Council Conclusions on Pandemic (H1N1) 2009*, pp. 2; 5-6.

vaccination to cover 75 per cent of high-risk population groups by 2010.[422] The European Parliament, in two previous Resolutions on pandemic influenza preparedness adopted in 2005 and 2006 respectively, had also urged Member States to increase seasonal influenza vaccination coverage.[423]

The rationale behind the Commission Proposal stemmed from what the Commission identified as two interlinked objectives: '(1) to combat the burden of seasonal flu and (2) to adjust the production capacity of flu vaccines in the EU in order that, in the event of a pandemic, the vaccine manufacturers can provide the amount of vaccines needed to cope with such a situation.'[424] The proposal thus linked vaccination for seasonal influenza with pandemic influenza preparedness:

> The health of EU citizens depends on having an agreed approach to the mitigation of seasonal influenza, a disease responsible in recent times for several severe pandemics. The 1918 'Spanish' Flu pandemic, for instance was responsible for more deaths than the WW1 military operations. Given the large scale movements of people in the EU a pandemic influenza virus can spread very rapidly through the population and take advantage of weaknesses in vaccination and preparedness. The great discrepancies among Member States in vaccination coverage against seasonal influenza indicates that there is an important potential for reducing the burden of the disease in Europe in at risk groups that would be most beneficial to those Member States with lower vaccination coverage. In addition, the well being of the EU as a whole would benefit by ensuring that spread of disease is reduced, with significant savings in health terms but also in terms of economic loss avoided.[425]

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[422] World Health Assembly, *Prevention and Control of influenza pandemics and annual epidemics.*

[423] European Parliament, *European Parliament resolution on the strategy against an influenza pandemic*; European Parliament. *European Parliament resolution on pandemic influenza preparedness and response planning in the European Community*, P6_TA(2006)0259. Strasbourg, 14 June 2006.

[424] Commission of the European Communities. *Proposal for a Council Recommendation On seasonal influenza vaccination*. COM(2009) 353 final. Brussels, 13.7.2009, p. 2.

[425] Commission of the European Communities, *Proposal for a Council Recommendation On seasonal influenza vaccination*, p. 7.

The Commission Proposal adopted a similar security reasoning for seasonal influenza vaccination coverage to that of pandemic preparedness by not only linking seasonal vaccination to the vulnerability of the European space to a pandemic influenza and the need for common defences to counter it, but by also evoking the possibility of a 1918 pandemic influenza-like scenario. The justification for the need for a coordinated EU effort to increase seasonal vaccination coverage thus echoed prior iterations of the security basis for pandemic preparedness in previous years. In this respect, the push for seasonal vaccination coverage can be considered an attempt at enhancing pandemic preparedness and vaccine production capacities by normalising influenza vaccination through its institutionalization as a routine seasonal response.

The Commission Proposal thereby suggested that the Council adopt a Recommendation on seasonal influenza vaccination that offered a set of measures for Member States to implement in order to reach a vaccination coverage of 75 per cent of at risk groups by the winter of 2014/15 at latest. The Council adopted the Commission Proposal on 22 December 2009 in the form of a Recommendation, which 'encouraged' Member States to 'adapt and implement national, regional or local action plans or policies, as appropriate, aimed at improving seasonal influenza vaccination coverage.'[426] While not a binding agreement, the Recommendation did represent one means of attempting to sustain preparedness efforts in the long term.

On 23 November 2009, in response to the Council Conclusions on health security adopted in December 2008 and to the Council Conclusions on H1N1 of 30

[426] *Council Recommendation of 22 December 2009 on seasonal influenza vaccination*. OJ L 348/71, 29.12.2009. Worth noting here is the shift in language from the proposed language in the Commission's draft, which stated that 'Member States *should* [emphasis added] adopt and implement a national action plan aimed at improving vaccination coverage...' See Commission of the European Communities, *Proposal for a Council Resolution On seasonal influenza vaccination*, pp.10-11.

April 2009, the Commission produced a Commission Staff Working Document on health security in the European Union and internationally. In addition to outlining the Commission's initial response to the Council's previous request for a legislative proposal formalizing the EU's health security framework, the Working Document also sought to respond to the WHO's call for action on health security as outlined in its 2007 World Health Report, *A Safer Future*. The key objective of the Working Document was to describe the strategic framework in place for health security at Union level, including the activities of the Health Security Committee. The Document described the background for the strategic framework on health security as follows:

> The strategic policy framework on health security was developed after the terrorist attacks in the USA on 11 September 2001 and the subsequent anthrax scare. Other health threat incidents in Europe have also helped to shape the approach of the EU. In particular, the threat of CBRN agents, ranging from natural disease outbreaks to deliberate attacks, has demonstrated the need to be prepared for large-scale public health emergencies with significant international impact. Foreign security policy makers have recognised this by creating a clear priority to put global health security higher on foreign policy agendas.
>
> Increasingly new and re-emerging health threats such as Severe Acute Respiratory Syndrome (SARS), avian influenza A(H5N1) and most recently the pandemic (H1N1) 2009 as well as climate change, are causing new disease patterns requiring a new approach towards European cooperation on health security challenges. In addition, the challenges arising from economic and social globalisation call for intensified global collaboration and solidarity in facing health security threats today and in the future.[427]

The Working Document thereby made reference to previous crisis events to reinforce the need for a strong coordinated approach at Union level to address what

[427] Commission of the European Communities. *Commission Staff Working Document: Health Security in the European Union and Internationally*. SEC(2009) 1622 final. Brussels, 23.11.2009, pp. 3-4.

was once again referred to as a new type of threat to the Union. The Working Document continued by outlining the three main areas of work covered by the EU health security framework: prevention of health threats; preparedness; and response to threats.[428] The Commission also expressed the intent in the Working Document of organising an international conference on global health security and pandemic preparedness under the Belgian Presidency in 2010 as a means of bringing together stakeholders to discuss means of jointly addressing future global health challenges.

On 1 December 2009, the Council held its 2980th meeting during which a discussion on developments concerning the influenza A(H1N1) pandemic was held as a follow up to the previous Council Conclusions adopted on 12 October 2009. Then-ECDC Director, Zsuzsanna Jakab, addressed the Council and Commissioner Vassiliou with an updated report on the A(H1N1) influenza pandemic situation. In her speech to the Council, Mrs. Jakab stated that the pandemic was 'a very significant threat to public health in the European Union', advising Europeans offered vaccines to counter the virus to take them. She also stressed the need for Member State health authorities to work with EU institutions in providing accurate and consistent information to the public on the influenza pandemic. This included the need for a joint statement endorsed by Member States, the WHO, the European Commission, the EMA and the ECDC on the importance of vaccination in countering the pandemic.[429]

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[428] Commission of the European Communities, *Commission Staff Working Document: Health Security in the European Union and Internationally*, p. 3.
[429] Jakab, Z. 'ECDC situation update on A (H1N1) influenza pandemic', *Speaking Note: Employment, Social Policy, Health and Consumer Affairs Council*. Brussels, 1 December 2009.

The Council discussion that followed focused on two issues: First, what had been learned so far from the pandemic with respect to issues pertaining to vaccine availability, vaccine strategy, regulatory procedures, communication to the public, global cooperation and multi-sectoral matters; and second, what challenges remained to be addressed.[430] While Health Ministers at the Council meeting generally agreed that the response to the pandemic had been successful, they also stressed the importance of strengthening coordinated communication efforts and vaccination. On this latter point, the Health Ministers welcomed the Commission's proposal for a virtual stockpile of vaccines and antivirals, and lent support to the idea of sharing surplus vaccines, asking for legal clarification on both issues. Furthermore, the Health Ministers called for strengthened efforts to counter the spread of disinformation regarding vaccination and to enhance communication efforts, while also requesting that more attention be paid to multisectoral issues in preparedness efforts.[431]

On the same day, the Commission adopted its updated technical guidance document on generic preparedness planning for public health emergencies in the Union. The revised document built upon the previous document of 2005 by encompassing a broader spectrum of threats to health than communicable disease and CBRN threats alone. The rationale for generic preparedness planning provided in the updated technical guidance document was expressed in the following terms:

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[430] Council of the European Union. *2980th Council meeting: Employment, Social Policy, Health and Consumer Affairs.* 16611/2/09 REV 2 (en) (Presse 348). Brussels, 30 November – 1 December 2009, p. 18.
[431] Council of the European Union, *2980th Council meeting*, pp. 18-19.

> Existing and future health threats are forcing countries all over the world to review, adapt and impose plans for large-scale health emergencies. Their past plans were often geared towards managing the consequences of events linked to particular diseases or other threats to health. Subsequently a lot of effort went into improving plans to face up to deliberate releases of chemical, biological, radiological and nuclear (CBRN) agents that were thought to be likely candidates for terrorist acts.
>
> With the advent of SARS, there came the realisation of the possibility of new, previously unknown agents causing many casualties and huge economic losses. Extensive flooding and heat waves were demonstrating the impact of climate change on health. Moreover, an influenza pandemic is a permanent cause of concern for health authorities all over the world, and the recent pandemic (H1N1) has shown the importance of a coordinated approach and well defined and thoroughly developed structures for the success of any control measures taken. The implications for organising safeguards and preparing for this vast array of threats are enormous. It was soon realised that the same personnel and assets would have to be mobilised and deal with the various emergencies. The need became clear for an overall health emergency preparedness plan with as many streamlined and harmonised components as possible, to cope with various kinds of emergencies such as CBRN events, environmental threats, and other events that could threaten health.[432]

As with the 2005 generic preparedness document, the updated technical guidance document outlined the main public health tasks associated with the key aspects of generic preparedness planning identified in the document: information management; communication; scientific and evidence-based advice; health crisis management structures; health sector preparedness; inter-sectoral collaboration

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[432] European Commission Health and Consumers Directorate-General. *Strategy for Generic Preparedness Planning: Technical guidance on generic preparedness planning for public health emergencies 2009 12 01*. Available from: http://ec.europa.eu/health/preparedness_response/docs/gpp_technical_guidance_document_1_december_2009.pdf [Accessed on 03 September 2012], p.1. A second updated technical guidance document on generic preparedness planning was subsequently adopted in April 2011. See European Commission Health and Consumers Directorate-General. *Strategy for generic preparedness planning: Technical guidance on generic preparedness planning for public health emergencies. Update April 2011.* Available from: http://ec.europa.eu/health/preparedness_response/docs/gpp_technical_guidance_document_april2011_en.pdf [Accessed on 29 October 2012].

and the management of plans.[433] Within the context of the updated technical guidance document, then, pandemic influenza was subsumed under the threat posed by communicable diseases generally, and situated alongside CBRN events and the health aspects of climate change as similar events requiring preparedness planning.

Efforts to improve coordination at EU level continued in the months leading up to and following the declaration by the WHO on 10 August 2010 that the 2009 A(H1N1) pandemic was over and that the world was 'now moving into a post-pandemic period.'[434] On 16 April 2010, the Commission produced an assessment report on the Union's response to the pandemic as a part of the on-going review of pandemic planning at Union level. The report documented the findings of an independent review undertaken by the UK Health Protection Agency on Member State and Commission activities in the first four months of the pandemic (24 April to 31 August 2009). The review itself was requested by the Commission in place of a cancelled EU-wide pandemic exercise that was originally scheduled for 2009 prior to the A(H1N1) outbreak.[435] Taking the place of the originally scheduled exercise, the 2009 influenza A(H1N1) pandemic thus functioned as a 'live action' exercise that served a similar purpose of highlighting the strengths and weaknesses of preparedness efforts to date.

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[433] European Commission Health and Consumers Directorate-General, *Strategy for Generic Preparedness Planning 2009 12 01,* p. 4.

[434] World Health Organization. *H1N1 in post-pandemic period*. Available from: http://www.who.int/mediacentre/news/statements/2010/h1n1_vpc_20100810/en/index.html [Accessed 29 October 2012].

[435] Health Protection Agency. *Assessment Report on the EU-wide Response to Pandemic (H1N1) 2009* (Salisbury, Health Protection Agency, 2010).

A second assessment report was published on 25 August 2010 and focused on pandemic vaccine strategies across the Union. The aim of the second report was to 'capture the diverse pandemic vaccine strategies (with special emphasis on communications issues) developed by the MS, and their experiences in implementing them, in order to provide a point of departure for improving MS and EU preparedness for future pandemics.'[436] A technical workshop was also held from 29-30 April 2010 on multisectoral issues during a health crisis, drawing specifically from the experiences of the A(H1N1) influenza pandemic, as a means of further developing EU-level preparedness and response capacities to future health crises.[437]

The 2009 influenza A(H1N1) pandemic, then, was yet another crisis event that reinforced the securitization process already underway at EU level. In this instance, the pandemic event itself provided the test exercise for strengthening preparedness and response efforts for the next pandemic to come. On the one hand, the 2009 outbreak event was subsumed in processes already underway at Union level, serving as another example of a crisis event that reinforced securitizing arguments and activities already in progress. On the other hand, the 2009 influenza A(H1N1) pandemic brought to the fore a particular set of response challenges that provided the basis for a review of lessons learned and that triggered the push for a further set of measures at Union level to confront the threat of pandemic.

In this respect, as with previous crisis events, the 2009 influenza A(H1N1) pandemic served to propel the process of securitization forward, introducing an

[436]Crismart & Health Protection Agency. *Assessment Report on EU-wide Pandemic Vaccine Strategies* (Salisbury & Stockholm, Health Protection Agency & Crismart, 25 August 2010).
[437] Council of the European Union. *Council Conclusions on Lessons learned from the A/H1N1 pandemic – Health security in the European Union*. 3032nd General Affairs Council Meeting, Brussels, 13 September 2010, p.1.

imperative to strengthen Community arrangements to date, particularly on the issues of risk assessment and communication, and the acquisition of medical countermeasures. Thus, despite raising criticisms concerning the overestimation of threat and the proportionality of response efforts – criticisms that will be turned to next, the 2009 influenza A(H1N1) pandemic event ultimately did not undermine the securitization process to date, but rather provided a structural force for further cooperation and coordination at Union level.

The 2009 influenza A(H1N1) pandemic and the review of lessons learned

As has already been suggested, the process of securitization underway in the years leading up to the 2009 influenza A(H1N1) pandemic outbreak ensured the relative success of response efforts at Union level to the extent that plans were in place to respond to the virus. However, this same securitization process also raised a number of logistical challenges in responding to the pandemic event, particularly as it concerned the 1918-like influenza scenario underpinning planning assumptions and the inability of plans to adapt to what was ultimately a relatively mild pandemic scenario. The juxtaposition of the in-built expectation of a more severe scenario with the relatively mild nature of the 2009 influenza A(H1N1) pandemic spurred criticisms as to the overestimation of the seriousness of the threat and the misappropriation of resources in responding to the pandemic.

These criticisms were made most explicit in a Council of Europe report on the A(H1N1) pandemic response.[438] The report asserted that the 2009 pandemic response resulted in a 'distortion of priorities of public health services across Europe, waste of large sums of public money and also unjustified scares and fears about the health risks faced by the European public at large.'[439] These criticisms were not only directed at the EU and individual Member States, but also at the WHO, the Council of Europe report questioning the transparency of decision-making processes during the pandemic as well as the possible role of the pharmaceutical industry in influencing decisions taken.[440] The report provided the background for a Council of Europe Parliamentary Assembly Resolution which reiterated the concerns articulated in the report and called for a number of measures to be taken to increase accountability and transparency in decision-making processes in addressing such major public health events as an influenza pandemic.[441]

The criticisms regarding the overestimation of the threat posed by the pandemic raised concerns as to whether the 2009 influenza A(H1N1) pandemic and

[438] Note that the Council of Europe is not an EU institution. The Council of Europe is a separate international organization that promotes cooperation throughout Europe on the basis of the common values of human rights, democracy and rule of law.
[439] Council of Europe Parliamentary Assembly. *The handling of the H1N1 pandemic: more transparency needed.* Doc. 12283, 7 June 2010.
[440] Council of Europe Parliamentary Assembly, *The handling of the H1N1 pandemic*. The criticisms directed at the WHO in the Council of Europe report on the H1N1 pandemic were later addressed in a WHO review on the functioning of the IHR during the pandemic and the WHO's response to H1N1. The WHO review committee behind the report was chaired by Dr. Harvey Fineberg. The report offered three summary conclusions on the WHO lessons learned from the A(H1N1) pandemic: First, the IHR were useful in responding to public health emergencies, but core national and local capacities had yet to be fully operationalized; second, the WHO generally performed well during the 2009 pandemic and, importantly, there was no evidence of malfeasance in terms of the manner in which the WHO conducted itself during the course of the pandemic; and third, the world remained poorly prepared to confront a severe influenza pandemic or any similar emergency. See World Health Organization. *Implementation of the International Health Regulations (2005): Report of the Review Committee on the Functioning of the International Health Regulations (IHR) in relation to Pandemic (H1N1) 2009*. A64/10, 5 May 2011, pp. 11-12.
[441] Council of Europe Parliamentary Assembly. *Handling of the H1N1 Pandemic: More Transparency Needed*. Resolution 1749 (2010), 24 June 2010.

the response to it would undermine preparedness efforts to date. In a statement delivered to the WHO review committee on the functioning of the International Health Regulations during the pandemic, ECDC Director Mark Sprenger expressed concern that the challenges posed by risk perception and criticisms of overreaction would mean that funding for vaccines and preparedness would be more difficult to secure in future and that public confidence in vaccination programmes in general would be undermined.[442]

Significantly, however, rather than undermine the securityness of pandemic influenza, these criticisms provided the basis for further cooperation and coordination at Union level. As such, they lent credence to the securitization process underway. In fact, while the Council of Europe report on the handling of the A(H1N1) pandemic was highly critical of the manner in which the pandemic was managed, importantly, the report did not dismiss the need for pandemic preparedness and response measures. Rather, it argued for the need to acknowledge and address the shortcomings in responses to the 2009 influenza A(H1N1) pandemic as a means of ensuring a more effective, transparent and proportionate response to a future outbreak.[443] Rather than undermine or reject the securitization process, then, the shortcomings in the A(H1N1) pandemic response provided the basis for a review of lessons learned aimed at improving preparedness and response activities and procedures at Union level precisely as a means of ensuring a more effective and efficient response to the next pandemic.

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[442] Sprenger, M. 'Lessons Learned from the 2010 Pandemic.' *Oral evidence to Fineberg Committee*. Geneva, 28 September 2010, p. 3.

[443] Council of Europe Parliamentary Assembly, *The handling of the H1N1 pandemic*.

The need to enhance risk assessment, management and communication in preparing for and responding to a pandemic eventuality was taken up in the review of lessons learned by the Commission, the Parliament, the Council, the ECDC and the EMA respectively. From 1-2 July 2010, in keeping with the intent expressed by the Commission in the Commission Staff Working Document on Health Security, the Council, under the Belgian Presidency, held a conference in cooperation with the Commission on lessons learned from the 2009 influenza A(H1N1) pandemic. The conference was attended by Member State national experts, as well as representatives from the Commission, the European Parliament, the EMA, the ECDC and the WHO. Representatives from the US, Canada, the EU's candidate countries and neighbouring countries were also present.[444]

The topics discussed at the conference fell under four themes: surveillance; multi-sectoral aspects of preparedness; communication; and medical countermeasures. Addressing the issues surrounding risk assessment, risk management and risk communication raised by the A(H1N1) response, the conclusions reached at the conference stressed the need for continued investment in national surveillance centres and in research so as to improve the ability to predict the impact of a pandemic, the need to improve communication strategies related to crisis management and medical countermeasures, and the need to strengthen the multi-sectoral aspects of preparedness through the development of national capacities and through the implementation of the IHR. The conclusions also endorsed the call for an EU joint procurement mechanism for vaccines and antivirals

[444] Council of the European Union, *Council Conclusions on Lessons learned from the A/H1N1 pandemic*, p. 5.

as a means of both ensuring 'equitable access at the lowest price' and increasing authorities' negotiating power with the pharmaceutical industry.'[445]

On 13 September 2010, the General Affairs Council adopted Conclusions on the lessons learned from the A(H1N1) pandemic. The Conclusions reiterated the need to enhance the coordination of national measures at EU level in order to strengthen preparedness within the Union and temporarily prolonged the mandate of the Health Security Committee until a permanent solution to the body was agreed upon. The Conclusions also invited Member States to continue to improve coordination and collaboration with the EU in addressing Public Health Emergencies of International Concern (PHEIC) as defined by the IHR, including improving the coordination of public communication strategies, and enhancing surveillance and analysis capacities.[446] Member States and the Commission were once again invited to examine options for providing the HSC with a legal basis and to also consider collaborating on joint procurement and a common approach to negotiating contracts with the pharmaceutical industry on medical products.[447] Additionally, the Conclusions invited the Commission to revise the EU's pandemic preparedness plan in light of the lessons learned from the 2009 pandemic, to develop a mechanism for joint procurement of vaccines and antivirals, to improve the fast registration procedure for vaccines, and to present in 2011 a proposal for a long-term solution on

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[445] Council of the European Union, *Council Conclusions on Lessons learned from the A/H1N1 pandemic*, pp. 5-8.
[446] Council of the European Union, *Council Conclusions on Lessons learned from the A/H1N1 pandemic,* p. 3.
[447] Council of the European Union, *Council Conclusions on Lessons learned from the A/H1N1 pandemic,* pp. 3-4.

health security in the Union – a request first made in the Council Conclusions on health security in 2008.[448]

The European Parliament held its own workshop on the A(H1N1) pandemic on 5 October 2010, the aim of which was to evaluate the actions of the EU institutions and relevant agencies during the pandemic. Dr. Mark Sprenger, Director of the ECDC, addressed the Parliament in a speaking note in which he offered three lessons from the ECDC on future preparedness planning: (1) the need for public health experts 'to produce more sophisticated and early assessments of the level and type of threat posed by new viruses'; (2) the need for more sophisticated analysis of the level of risk justifying public investment in the development and deployment of vaccines; and (3) the need for more sophisticated risk communication. Dr. Sprenger also argued for the need for more sophisticated data collection systems in Europe, including the need to invest in national public health institutes, laboratories and systems as a means of ensuring quality of data.[449]

The proceedings from the workshop were summarized in a European Parliament report. Echoing criticisms made in the Council of Europe report on the 2009 pandemic response, the report conveyed concerns raised at the workshop by a number of MEPs that 'the purchase of large quantities of vaccines that were never used in some Member States led to a waste of public resources, unnecessary fears

[448] Council of the European Union, *Council Conclusions on Lessons learned from the A/H1N1 pandemic,* p. 4.
[449] Sprenger, M. 'Question to be answered – What changes should be made to EU response planning, in particular with regard to ensuring independence, excellence and transparency of decision-making?' *Speaking Note at the Hearing on H1N1, European Parliament*. Brussels, 5 October 2010.

on the part of the public and a loss of credibility in EU institutions.'[450] The report also raised the need for external experts in risk assessment and vaccination authorization procedures, the need to define the roles of EU bodies in addressing health crises, the need to examine the relationship between the EU and the WHO and the need for independence in decision making, the need to improve public communication and coordination amongst the EU and the Member States, and the need for better early risk assessment on the level and type of threat posed by a disease outbreak.[451]

Importantly, then, just as with the Council of Europe report, although the European Parliament report was highly critical of the response to the 2009 A(H1N1) outbreak in the EU, the report did not signal a move towards desecuritization, but rather argued for the need to sharpen risk assessment and risk communication capabilities in order to provide a more proportionate response to any future outbreak. In keeping with the Council Conclusions on the lessons learned from the A/H1N1 pandemic, the European Parliament report also flagged the need to improve the legal basis for addressing communicable diseases in the Union.[452]

Following the workshop, on 8 March 2011, the European Parliament adopted a Resolution on the evaluation of the management of the influenza A(H1N1) pandemic. Echoing previous assertions as to the need to enhance risk assessment, the Resolution maintained that there was a need to consider the virulence of an influenza outbreak along with the propagation of the virus in any future public

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[450] European Parliament. *Proceedings of the Workshop-Hearing 'Evaluation of the Management of H1N1 influenza in 2009-2010 in the EU'*. PE 447.510, October 2010, p.5.
[451] European Parliament, *Proceedings of the Workshop-Hearing 'Evaluation of the Management of H1N1'*, p. 5.
[452] European Parliament, *Proceedings of the Workshop-Hearing 'Evaluation of the Management of H1N1'*, p. 5.

health response to an influenza outbreak, and called for a number of measures to be taken to improve preparedness and response capacities in the Union. These included revising preparedness plans to improve their flexibility, reviewing the roles and remits of key EU actors in countering health threats, improving coordination between Member States and the Commission, revising the WHO definition of pandemic to include a consideration of severity, increasing the amount of EU resources devoted to research on preventive public health measures, continuing to invest in national surveillance systems, and enhancing communication strategies.[453]

The Resolution welcomed the Commission intention to provide the HSC with a legal basis and expressed support for the establishment of a voluntary joint procurement mechanism, arguing that 'the limited cooperation among Member States, especially the lack of joint public procurement of vaccines, the lack of joint stockpiles, the lack of a solidarity and brokerage mechanism between Member States, and the absence of prior purchase agreements in several Member States were the main factors undermining the EU's better preparedness.'[454] The Resolution also argued for the need to ensure the independence of the ECDC in accounting for the severity of an infection risk. On this point, the Resolution invited the ECDC, in consultation with the WHO, to contribute to reviewing and making recommendations on best practice on national influenza preparedness plans.

The Resolution additionally called for an assessment of influenza vaccination strategies within the Union, requesting the creation of a European code of conduct

[453] European Parliament. *European Parliament resolution of 8 March 2011 on evaluation of the management of H1N1 influenza in 2009-2010 in the EU (2010/2153(INI))*, P7_TA(2011)0077. Strasbourg, 8 March 2011.
[454] European Parliament, *European Parliament resolution of 8 March 2011 on evaluation of the management of H1N1 influenza in 2009-2010 in the EU*.

on the role of scientific experts in European authorities charged with the safety and management of risks, and stating that conflicts of interest among experts advising the European public health authorities must be avoided.[455] The Resolution argued for 'studies independent of pharmaceutical companies on vaccines and antiviral medications.'[456] Once again, in raising these criticisms, the Resolution did not reject the securityness of pandemic influenza per se, but rather asserted the need to clarify roles and responsibilities of actors engaged in assessing and managing risks associated with various aspects of pandemic influenza preparedness and response as a means of ensuring an appropriate and more transparent response in future.

In keeping with some of the lessons identified by both the Council and the Parliament, both the ECDC and the EMA in their respective reviews of the A(H1N1) pandemic maintained that there was a need to improve the flexibility of preparedness plans, to improve public communication strategies, to strengthen surveillance, and to increase research 'into new technologies, into the disease itself, and into methodologies on the detection of safety signals during a pandemic.'[457] An initial ECDC report on the 2009 influenza A(H1N1) pandemic in Europe maintained that the early detection of the virus strain, the preparedness efforts that had been underway in Member States over the course of the past five years and the existence of effective pharmaceutical measures were positive aspects of the pandemic response in the Union. However, raised expectations of severity stemming from the

[455] European Parliament, *European Parliament resolution of 8 March 2011 on evaluation of the management of H1N1 influenza in 2009-2010 in the EU.*
[456] European Parliament, *European Parliament resolution of 8 March 2011 on evaluation of the management of H1N1 influenza in 2009-2010 in the EU.*
[457] European Medicines Agency. *Pandemic report and lessons learned: Outcome of the European Medicines Agency's activities during the 2009 (H1N1) flu pandemic*. EMA/221017/2011. 29 April 2011, pp.11-12; European Centre for Disease Prevention and Control, *The 2009 A(H1N1) pandemic in Europe*, p. 2.

previous period of preparation and investment led to 'popular (mis)perceptions of severity' that posed a particular challenge to address, alongside the challenge of vaccine distribution.[458] The report continued by arguing that the majority of preparedness plans were based on the expectation of a more severe pandemic and as such, there was a need to build greater flexibility into future plans to accommodate a range of scenarios. Moreover, the concept of severity needed to be further developed by 'acknowledging its complexity but not neglecting the other essential parameters for mitigation.'[459]

A second ECDC report corroborated the findings of the previous one, maintaining that while the ECDC provided added-value in responding to the pandemic in the EU, the lack of a clear means of communicating and evaluating severity contributed to a gap between the ECDC's scientific advice and the decisions of Member State authorities.[460] The report stated:

> In the case of the pandemic, a general overview lead [*sic*] to the conclusion that Member States were more closely listening to scientific advice than in the past, but there was also an evident distance, especially in sensitive areas such as procurement of medicines or vaccines, and in communication to the public. This happened despite the fact that most of the ECDC scientific positions were the result of a process of evidence gathering in which many of the Member States experts had directly participated. This decision support gap represents a long-lasting dilemma for which there is no simple solution. However, it does indicate the need to produce scientific advice that becomes more consequential and is accompanied by surveillance systems, evaluations,

[458] European Centre for Disease Prevention and Control, *The 2009 A(H1N1) pandemic in Europe*, pp. 37-9.
[459] European Centre for Disease Prevention and Control, *The 2009 A(H1N1) pandemic in Europe*, p. 39.
[460] Greco, D., EK Stern & G. Marks. *Review of ECDC's response to the influenza pandemic 2009/10* (Stockholm, ECDC, 2011), pp. 1, 26, 32.

> and operations that allow the Member States to evaluate and implement required and relevant scientific advice and supportive actions.[461]

Key recommendations provided by the report included the need to modify the public health event (PHE) alert system to avoid risk of politicization, the development of a general PHE communication strategy, the inclusion of socio-demographic characteristics of populations involved in early assessments of the threat posed by new viruses, the need to improve the evaluation of risk levels that justify public investment into vaccine development and deployment, the development of risk communication strategies suited to changes in communication technologies, and the need to invest in national public health institutes, laboratories and systems.[462]

On 18 November 2010, the European Commission adopted its own review of the 2009 pandemic in the form of a Commission Staff Working Document entitled 'on lessons learnt from the H1N1 pandemic and on health security in the European Union.'[463] The purpose of the Working Document was to report on progress made and to outline future action of the Commission services with respect to preparing for and managing cross-border health threats in the EU. In keeping with securitizing arguments presented in previous Commission documents, the Working Document described the 2009 influenza A(H1N1) pandemic as 'a reminder of the potential of pandemic influenza to cause widespread illness, death and societal disruption', stating that while the A(H1N1) pandemic was milder than initially anticipated, it nevertheless 'emphasised the need to reinforce cooperation between Member

[461] Greco et al., *Review of ECDC's response to the influenza pandemic 2009/10*, p.32.
[462] Greco et al., *Review of ECDC's response to the influenza pandemic 2009/10*, p. 32.
[463] European Commission. *Commission Staff Working Document on lessons learnt from the H1N1 pandemic and on health security in the European Union*. SEC(2010) 1440 final. Brussels, 18.11.2010.

States within the EU in the management of the response to a pandemic.'[464] The 2009 A(H1N1) pandemic event thus functioned to reassert the securityness of the threat of pandemic influenza independent of the threatening qualities of the 2009 pandemic event itself.

On the basis of this argumentation and in keeping with the opinions expressed by both the Council and the Parliament, the Commission Staff Working Document proposed to improve preparedness and response in the Union by creating a proposal on mechanisms for joint procurement of vaccines and antivirals as a means of assisting in improving Member States' purchasing power and equitable access, and by updating the guidance document on pandemic preparedness and response planning.[465] The updated guidance document was to have the three-fold aim of improving the resilience of the health sector across Europe, strengthening preparedness and response in sectors other than health, including their interoperability, and increasing cooperation between all relevant stakeholder both within the EU and internationally.[466] The Working Document emphasized, however, that EU-level preparedness and response efforts did not just have to be strengthened in the area of communicable diseases, but also with respect to 'other serious cross-border health threats whatever the origin of the threat.'[467]

The Commission Staff Working Document provided the backdrop to the Commission Proposal for a Decision of the European Parliament and of the Council on serious cross-border threats to health (previously referred to as the health

[464] European Commission, *Commission Staff Working Document on lessons learnt from H1N1*, p. 3.
[465] European Commission, *Commission Staff Working Document on lessons learnt from H1N1*, p. 3.
[466] European Commission, *Commission Staff Working Document on lessons learnt from H1N1*, pp. 4-5.
[467] European Commission, *Commission Staff Working Document on lessons learnt from H1N1*, p. 3.

security initiative), adopted by the Commission on 8 December 2011 and the subject of the next chapter. In drawing from the experiences with the 2009 influenza A(H1N1) pandemic and the lessons learned from it, the Commission Staff Working Document reasserted the continued importance of Community arrangements in confronting the threat of pandemic and in so doing, reaffirmed both the securityness of pandemic influenza as a threat subject and the need for continued coordination at EU level to respond to it.

Throughout and beyond the influenza A(H1N1) pandemic period, then, the Commission, the Council and the Parliament alike continued to push for further cooperation at the level of the EU in order to confront the next pandemic eventuality. Despite the relatively mild nature of the 2009 outbreak and the criticisms raised by responses to it, the securityness of pandemic influenza continued to be reaffirmed, the language of security continuing to be drawn upon as a means of justifying the need for additional collaboration. The 2009 influenza A(H1N1) outbreak, then, functioned to both reaffirm securitizing processes already underway at EU level and provide the impetus for the further consolidation of activities at EU level to date. The outbreak event thus marked another stage in the securitization process already underway. Despite weaknesses in response efforts to the 2009 influenza A(H1N1) pandemic, by the end of 2010, the securitization of pandemic influenza at the level of the EU had reached a heightened stage.

Conclusion

This chapter has sought to examine the 2009 influenza A(H1N1) pandemic in light of the process of securitization outlined in the previous chapter as a means of determining the impact that the 2009 influenza A(H1N1) pandemic had on the securitization process to date and vice versa. The chapter has argued that the 2009 influenza A(H1N1) pandemic was significant for developments at the level of the EU on two fronts: First, it was the first pandemic event to test preparedness plans, thereby providing a test case for examining the consequences of the securitization process outlined in previous chapters on an outbreak event. Second, the 2009 influenza A(H1N1) pandemic proved to be milder than initially anticipated, creating both logistical challenges in responding to the outbreak event and challenges regarding the perceived legitimacy and proportionality of response efforts. The 2009 influenza A(H1N1) pandemic, then, functioned to test the strength and credibility of the process of securitizing pandemic influenza at the level of the EU in the years leading up to the outbreak event.

The chapter has argued that despite the potential of the 2009 influenza A(H1N1) pandemic to undermine the process of securitizing pandemic influenza at the level of the EU, the 2009 outbreak event did not instigate a move towards desecuritization, but rather reinforced the securitization process already underway. Throughout and beyond the pandemic period, all three EU institutions continued to call for further cooperation and coordination at EU level in preparing for and responding to a pandemic eventuality, drawing on the shortcomings in the 2009 influenza A(H1N1) pandemic response precisely as a means of reinforcing the need

for a strengthened Community capacity to address an influenza pandemic. Reports from the Council of Europe and the European Parliament that were critical of the EU and WHO handling of the pandemic, moreover, did not deny the securityness of pandemic influenza, but rather asserted the need to strengthen capacities to ensure a more effective and efficient response to a pandemic in the future.

Additionally, throughout this time period, pandemic influenza continued to be framed by security language. The Commission Communication on Pandemic (H1N1) 2009 is of particular note in this regard as it not only drew on previous securitizing arguments concerning the potential impact of a pandemic on the economy and societal stability, but also referenced the potential of the pandemic to impact global, regional and national security. The outbreak event itself, moreover, functioned as a 'live action' exercise that tested the strength of the EU's preparedness apparatus to date. The 2009 influenza A(H1N1) pandemic thus served to support the securitization process already underway at the level of the EU, serving as another crisis event that reinforced previous securitizing arguments. The shortcomings in the pandemic response provided the basis for the 'lessons learned' from the pandemic experience and spurred the push for additional instruments at EU level to combat a pandemic eventuality. Rather than challenge the process of securitizing pandemic influenza, then, the 2009 influenza A(H1N1) pandemic was subsumed in it, functioning to propel the securitization process forward.

The chapter has argued, therefore, that the materiality of threat has continued to play an important role in the securitization process, despite the mild nature of the 2009 outbreak event itself. In this instance, the shortcomings in

response efforts brought forth by the 2009 influenza A(H1N1) pandemic provided the basis for arguments as to precisely why activities at EU level needed to be strengthened in order to be better prepared for the next pandemic to come. The 2009 pandemic thus served as a strategic means of advancing claims for a stronger Community response in combating an influenza pandemic independent of the threatening qualities of the event itself.

This not only indicates that the securityness of the threat of pandemic influenza continued to be broadly recognised throughout and beyond the 2009 pandemic period, but also speaks to the cyclical nature of pandemic influenza as a threat subject. The threat of pandemic influenza has thereby provided a structural force for further cooperation and coordination at Union level. By the end of 2010, then, it is possible to say that the process of securitizing pandemic influenza at the level of the EU had reached a heightened stage.

Chapter 5: The Proposal for a Decision on serious cross-border threats to health

Introduction

This chapter focuses on the period following the 2009 influenza A(H1N1) pandemic and specifically, on the introduction of the Commission Proposal for a Decision on serious cross-border threats to health. The aim of the chapter is to analyse the Commission's proposed Decision and the debates that have emerged from it in light of the process of securitizing pandemic influenza outlined in previous chapters as a means of not only determining whether pandemic influenza can in fact be considered securitized at the level of the EU, but also what this process of securitization suggests about the management of health threats in the Union. The chapter thus seeks to respond directly to the research questions underpinning this thesis – namely, has pandemic influenza been securitized at EU level and with what consequences for the role of the EU as a provider of health security?

The chapter argues that the Commission Proposal for a Decision on serious cross-border threats to health carries significance for the process of securitizing pandemic influenza at the level of the EU on three interrelated fronts: First, the Proposal is a direct response to the Council requests in both 2008 and 2009 for a legislative proposal formalizing the EU's health security framework. In this respect, the Commission Proposal constitutes a next step in the securitization process documented to date and provides the Commission with a platform to assert a

stronger role for itself as a health security provider in the Union. Second, the proposed Decision follows on the heels of experiences with the 2009 influenza A(H1N1) pandemic. A key feature of the Proposal is therefore the 2009 influenza outbreak and the lessons learned from it. Third, the Proposal follows the entry into force of the Lisbon Treaty. In addition to granting the EU legal personality, the Treaty of Lisbon strengthened the role of the Commission and expanded its health protection mandate by including 'monitoring, early warning and combating serious cross-border threats to health' to the list of Community activities.[468] The entering into force of the Treaty of Lisbon holds bearing for the securitization process in that it alters the basis upon which the Commission, as a predominant securitizing actor, can make securitizing claims.

The chapter thus argues that the Commission Proposal for a Decision on serious cross-border threats to health provided the Commission with the opportunity to assert itself as a securitizing actor. Taking advantage of the platform provided to it by the Council in its request for a Commission proposal for legislation formalizing the Community framework on health security, the Commission drew on the lessons learned from the 2009 influenza A(H1N1) pandemic to reassert the securityness of pandemic influenza and in so doing, to assert a stronger role for itself as a manager of health threats in the Union. Health threats in this context referred not only to emerging infectious diseases such as an influenza pandemic, but rather encompassed a broader range of risks with a potential public health dimension. The threat of pandemic influenza was therefore not only subsumed within a proposed

[468] *Consolidated Version of the Treaty on the Functioning of the European Union*. OJ C 115/112, 9.5.2008.

legislative framework that was broader in scope than communicable diseases alone, but also provided the structural force for this broadened scope and for further cooperation and coordination at Union level.

By the end of 2011, then, the securitization process had evolved from the recognition of pandemic influenza as a security threat, to the recognised need for institutionalized arrangements to confront it, to current debates on precisely how, in the moment of emergency, security is to be provided, by whom, in what capacity and following which procedures. Rather than signalling a taken-for-granted understanding of pandemic influenza as a security threat as suggested by the Copenhagen School's understanding of an institutionalized securitization, however, the chapter argues that the move towards institutionalization in this instance is necessarily a political one and subject to negotiation. At the heart of the securitization process is a tension between the Commission, the Council and to a lesser extent, the Parliament as to the appropriate role of the Commission and the extent of EU level involvement in managing health threats in the Union.

The chapter thus argues that while it is possible to say that the process of securitizing pandemic influenza at the level of the EU has currently reached a heightened stage, this securitization process is an ongoing one and one marked by points of contestation. While the Commission has been able to assert a stronger role for itself and a distinct role for the Union in managing cross-border health threats through the proposed Decision, the success of the Commission's securitizing arguments in this instance has only been partial. As such, the extent of executive

authority granted to the Commission in providing for health security within the Union is likely to remain limited.

The chapter begins by providing an overview of the main features of the Proposal and their implications for the process of securitizing pandemic influenza outlined to date. This includes a focus on the key Articles proposed by the Commission that hold bearing for the process of securitization documented thus far. Next, attention turns to the discussions that have taken place in the Council and the Parliament as to the various provisions in the Proposal and the positions of these two institutions on the Proposal to date. The chapter concludes with a discussion of what these developments mean for the process of securitizing pandemic influenza at the level of the EU.

The Commission Proposal for a Decision on serious cross-border threats to health

The Commission Proposal for a Decision by the Parliament and the Council on serious cross-border threats to health, adopted by the Commission on 8 December 2011, was in direct response to the 2008 and 2009 Council requests for legislation formalizing the EU's health security framework. The aim of the Proposal was 'to streamline and strengthen European Union capacities and structures for effectively responding to serious cross-border health threats', defined as 'events caused by communicable diseases, and threats of chemical, environmental, or unknown origin.'

This included 'threats of malicious intentional origins as well as threats derived from climate change.[469] The justification for the Proposal was stated as follows:

> Although the Member States have the responsibility to manage public health crises at national level, no country can tackle a cross border public health crisis on its own….Recent cross-border events such as the H1N1 pandemic in 2009, the volcanic ash cloud and the toxic red sludge in 2010, or the outbreak of *E. coli* STEC 0104 in 2011, had significant effects on society and demonstrated that none of the impacts of these emergencies can be confined to only one sector. Therefore, through improved multi-sectoral cooperation at EU level other sectors need to be equally prepared to manage the impacts of a public health crisis.
>
> At EU level, the legal basis for addressing serious cross-border health threats has been reinforced with the Lisbon Treaty. The EU can now take action in this field, except for any harmonisation of the laws and regulations of the Member States. Also, the Treaty stipulates that the EU must complement and support national policies and encourage cooperation between Member States, without superseding their competence in that field.[470]

The significance of the Proposal for the securitization of pandemic influenza at the level of the EU is three-fold: First, it expanded the scope of health security beyond a focus on communicable diseases and CBRN threats to encompass a broader array of incidents with potential public health consequences. Thus, not only did the Proposal seek to embed pandemic preparedness and the threat of pandemic influenza within a legislative framework that was broader in scope than communicable diseases alone, but also, in keeping with Lakoff's claim, the threat of pandemic influenza

[469] European Commission. *Proposal for a Decision of the European Parliament and of the Council on serious cross-border threats to health*. COM(2011) 866 final. Brussels, 8.12.2011, p. 2.
[470] European Commission, *Proposal for a Decision on serious cross-border threats to health*, p. 2.

provided the vehicle for a form of preparedness planning that encompassed a wider array of potential threats.[471]

The references to the volcanic ash cloud and toxic red sludge incidents in 2010 and the outbreak of E. coli in 2011 as health crises are significant in this regard. The outbreak of E. coli in Germany and France from contaminated sprout seeds not only directly impacted the health of individuals, including causing fatalities, but also resulted in significant economic losses for the fruit and vegetable sector. The toxic red sludge incident in Hungary risked harming the health of citizens due to the pollution caused by it and carried cross-border implications, while the volcanic ash cloud resulted in major economic losses for the aviation industry, although the direct public health impact is less obvious in this instance. All three of these incidents had cross-border implications and involved mobilising responses across various sectors across the EU. In all of these cases, that which is threatened is not just the health of EU citizens, but also the continued economic functioning of the Union as a whole. An additional feature uniting all these crises was the need for proactive measures to minimize the adverse impact caused by similar events in future. The threat of pandemic influenza thus provided a structural force for further cooperation and coordination at the level of the EU.

In fact, the glossary of terms in Annex 22 of the Commission Working Document on Impact Assessment accompanying the Commission Proposal provided the first explicit definition of health security by the EU to date, so far as this author is aware. Health security was defined in Annex 22 as ‘Activities required, both

[471] Lakoff, ‘From Population to Vital System’, p. 34.

proactive and reactive, to minimise vulnerability to acute public health events that endanger the collective health of populations living across geographical regions and international boundaries.'[472] A serious cross-border public health threat was defined as: 'An event of biological, chemical, radiological and nuclear or environmental origin or caused by climate change, with potentially severe consequences for public health which affects or could affect more than one Member State in such a way that the morbidity or mortality in humans is acute and rapidly growing in scale or is unusual for the given place and/or time.'[473] The definition of health security provided in Annex 22 thus drew directly from the World Health Organization's 2007 World Health Report, *A Safer Future.*

Second, the proposed Decision aimed to formalize institutional arrangements in addressing cross-border health threats within the Union. In keeping with the findings presented in the previous chapters, this marked a step from the recognised securityness of pandemic influenza, to the recognised need for formalized institutional arrangements to confront it. This process of formalization can be read as a means of institutionalizing pandemic influenza as a security issue given the recognised persistent and recurrent nature of the threat.[474] Importantly, however, rather than being a reflection of a necessarily taken-for-granted precedence of the threat of pandemic influenza on the political agenda as suggested by the Copenhagen School's understanding of an institutionalized securitization,

[472] European Commission. *Commission Staff Working Paper: Impact Assessment Accompanying the document Decision of the European Parliament and of the Council on serious cross-border threats to health*. SEC(2011) 1519 final. Brussels, 8.12.2011, p.130.
[473] European Commission, *Commission Staff Working Paper: Impact Assessment Accompanying the Document Decision on serious cross-border threats to health*, p. 131.
[474] Barry Buzan, Ole Wæver and Jaap de Wilde state: 'Securitization can be either ad hoc or institutionalized. If a given type of threat is persistent or recurrent, it is no surprise to find that the response and sense of urgency becomes institutionalized.' See Buzan et al., *Security*, p. 27.

institutionalization in this instance serves to ensure that preparedness efforts are sustained absent continued political priority or in the face of pandemic fatigue. Institutionalization is thus not the outcome of a successful securitization per se, but rather the next step in an ongoing securitization process. The move towards the institutionalization of arrangements at EU level thereby remains political and subject to negotiation.

Third, the Proposal provided the Commission with the opportunity to assert itself as a securitizing actor by pushing for further executive power on the basis of securitizing claims made. Significant in this regard is the fact that the Proposal followed the entering into force of the Lisbon Treaty on 1 December 2009. The Lisbon Treaty not only reinforced the role of the Commission in providing for public health protection within the Union, but also strengthened the powers of the Commission by introducing two types of acts: delegated acts and implementing acts. Whereas a delegated act enables the legislator of an initiative (in this case, the Parliament or the Council) to delegate powers to the Commission to implement acts that amend what are considered non-essential items of a piece of legislation, an implementing act strengthens the implementing powers of the Commission by enabling the Commission to adopt acts in those cases where uniform implementation of certain issues is deemed necessary.[475]

[475] European Union. *European Union legal acts* Available from: http://europa.eu/legislation_summaries/institutional_affairs/treaties/lisbon_treaty/ai0032_en.htm [accessed 30 September 2012]; European Parliament. *Legislating more efficiently: questions & answers on new delegated acts*. 24.03.2010. Available from: http://www.europarl.europa.eu/sides/getDoc.do?language=en&type=IM-PRESS&reference=20100323BKG71187 [Accessed on 1 May 2013].

The Commission Proposal for a Decision on serious cross-border threats to health thereby maintained that the Commission should be empowered to adopt delegated acts 'in order to supplement or amend certain non-essential elements of the basic act', as well as to adopt implementation acts '[i]n order to achieve uniform conditions for the implementation of the basic act, particularly with regard to the procedures for information sharing, consultation and coordination of preparedness and response.'[476] This strengthened position of the Commission thus provided the grounds for the Commission to assert itself more strongly as an actor throughout the proposed Decision and in so doing, seek to expand the authority granted to it in providing for public health protection within the Union.

The objectives of the proposed Decision were five-fold: (1) to improve preparedness and capacity building by ensuring the coordination between Member States national plans and between key sectors such as transport, energy and civil protection. This included providing support for the establishment of a joint procurement mechanism for vaccines and antivirals; (2) to set up an ad hoc network in situations where a serious threat other than communicable disease has been notified by a Member State as a means of improving risk assessment and monitoring of emerging threats; (3) to expand the use of the Early Warning and Response Network (EWRS) to encompass 'all serious threats to health' and not just communicable diseases; (4) to introduce 'coordinated development of national or European public health risk assessments for threats of biological, chemical, environmental or unknown origin in a crisis situation'; and (5) to establish 'a coherent framework for EU response to public health crisis', in particular by

[476] European Commission, *Proposal for a Decision on serious cross-border threats to health*, p. 10

providing the Health Security Committee with a legal basis.[477] The proposed Decision thus directly responded to previous requests made by both the Council and the Parliament to strengthen the framework for health security in the EU, including measures to improve cooperative arrangements within the Union following the experiences with the 2009 influenza A(H1N1) pandemic. Moreover, in so doing, it expanded the scope of the EU's health security framework to date to encompass not only a broader array of sources of threat, but also to integrate a broader array of sectors.

The added-value of EU level coordination was expressed in the Proposal on the basis of the need to ensure complimentarity across the EU in responding to health threats that are intrinsically transboundary in nature. Echoing previous arguments about European vulnerability to disease in light of globalization, the Proposal argued for the need for consistency in public health measures in containing serious cross-border threats to health, drawing from the challenges raised in responding to the 2009 influenza A(H1N1) pandemic in particular in asserting a stronger role for the Union in combating cross-border threats to health. The Proposal stated:

> Measures taken by an individual Member State to respond to such threats may touch upon the competences of the EU or other national governments, and can therefore damage the interests of Member States and run counter to the fundamental principles and goals of the EU if they are not consistent with each other and are not based on shared scientifically objective and comprehensive risk assessment.... With respect to the H1N1 pandemic in 2009, there was a drastic drop in medication compliance for pandemic

[477] European Commission, *Proposal for a Decision on serious cross-border threats to health*, p. 3.

> vaccines, potentially endangering the health of citizens, including health care workers, and jeopardising the capacity of the health sector to efficiently respond to that crisis. In addition, the pandemic led to economic losses for the Member States' budgets due to unused vaccines, resulting from the different public perceptions both about the severity of the threat and the safety and efficacy of those products. Furthermore, measures that are effective from a public health standpoint (e.g. isolation, quarantine, social distancing, workplace and school closures, travel advice and border controls) can have adverse consequences for civil liberties and the internal market. Therefore, the coordination of the response at Union level should ensure that measures taken at national level are proportionate and limited to public health risks related to serious cross-border health threats, and do not conflict with obligations and rights laid down in the Treaty, such as those relating to the restriction of travel and trade.[478]

On the basis of this argumentation and on the argument that action at Member State level alone would not be sufficient given the cross-border nature of the threats covered in the proposed Decision, the Proposal maintained that the adoption of EU measures was necessary to ensure effective action in confronting cross-border threats to health within the Union.

An accompanying Executive Summary on the impact assessment of the Proposal reinforced the need for coordinated risk assessment and risk management at EU level as a means of overcoming discrepancies in Member State preparedness that 'may lead to incoherent strategies, divergent standards, and inconsistent procedures and methodologies', and of avoiding 'mutually counterproductive measures.'[479] A lack of comprehensive risk assessment was also argued to have the potential to lead to unclear communication, in turn potentially undermining public confidence in measures taken or proposed by Member State public health

[478] European Commission, *Proposal for a Decision on serious cross-border threats to health*, pp. 9-10.
[479] European Commission. *Commission Staff Working Paper Executive Summary of the Impact Assessment. Accompanying the document Decision of the European Parliament and of the Council on serious cross-border threats to health*. SEC(2011) 1520 final. Brussels, 8.12.2011, p. 3.

authorities.[480] The challenges posed by the A(H1N1) pandemic response thereby served as examples in both the Commission Proposal and the Executive Summary as to precisely why more EU-level coordination was necessary. The crisis event provided a strategic means of advancing claims for a more coordinated preparedness and response effort in the EU and a stronger role for the Commission in this effort despite the relatively mild nature of the crisis event itself. The threat of pandemic influenza has thus served as a structural force for further EU-level coordination – a testament to the cyclical nature of the threat subject itself.

The Commission's Proposal for a Decision on serious cross-border threats to health: Key Articles

On the basis of the argumentation outlined above, the Commission Proposal introduced a number of Articles that asserted a stronger role for the Union in managing cross-border health threats. Three features of the Proposal are of particular mention in this regard: (1) the proposed strengthening of preparedness planning, including the provision of a voluntary joint procurement mechanism for influenza vaccines; (2) the proposed strengthening and formalization of the Health Security Committee; and (3) the proposed introduction of means to recognise health emergency situations in the EU and to implement emergency measures.

Planning was covered in Chapter II of the Commission's Proposal for a Decision on serious cross-border threats to health and included Article 4 on preparedness and response planning and Article 5 on the voluntary joint

[480] European Commission, *Commission Staff Working Paper Executive Summary of the Impact Assessment*, p. 4.

procurement of medical countermeasures. Article 4 outlined the duty of Member States to consult with the Commission, within the Health Security Committee, on preparedness planning as a means of 'coordinat[ing Member States'] efforts to develop, strengthen and maintain their capacities for the monitoring, early warning and assessment of and response to the serious cross-border threats to health.'[481] This included reporting to the Commission on the state of play of preparedness and response planning as it concerns minimum core capacity standards, specific mechanisms established to address the interoperability of plans across sectors, and business continuity plans for critical sectors of society.[482] The significance of Article 4 as proposed by the Commission is that it not only sought to strengthen the level of preparedness within and across Member States, but also granted the Commission a key role in managing this process.

Although not under the chapter on preparedness planning, Article 11 on coordination and response also reinforced the central role of the Commission in coordinating national responses to serious cross-border health threats within the Union. Article 11 stipulated that Member States were to consult each other and the Commission, within the Health Security Committee, on the coordination of national responses to the serious cross-border threat to health. This included consulting other Member States and the Commission on the nature, purpose and scope of measures intended to be adopted or, in the case of urgent implementation, on measures already adopted. Through the use of implementing acts, adopted following the examination procedure outlined in Article 20(2) of the proposed Decision, the

[481] European Commission, *Proposal for a Decision on serious cross-border threats to health*, p. 18.
[482] European Commission, *Proposal for a Decision on serious cross-border threats to health*, p. 18.

Article stated that the Commission could 'adopt procedures necessary for the uniform implementation of the mutual information, consultation and coordination provided for in this Article.'[483]

Article 20 of the proposed Decision referred to in Article 11 stipulated that in the case of the adoption of implementing acts, the Commission would be assisted by a Committee on serious cross-border threats to health. In accordance with Article 3(2) of Regulation (EU) No 182/2011, the Committee would be chaired by the Commission and be made up of Member State representatives. The Commission, as Chair, would not be able to participate in committee voting.[484] The examination procedure referred to in Article 20(2) was that outlined in Article 5 of Regulation (EU) No 182/2011, specifying the process of consultation that the Commission was to follow with the Committee before being able to adopt implementing acts.[485] Thus, in adopting implementing procedures on the coordination and response to a cross-border health threat, the Commission would have to first consult the proposed Committee on serious cross-border health threats. Article 11, then, reinforced the Commission's role as a coordinator of response efforts at Union level.

The role and composition of the Health Security Committee was addressed in Article 19 of the Commission Proposal. The Article stated that the Committee would be composed of Member State representatives and chaired by the Commission, and that the role of the Committee would be to 'assist' the Commission in conducting its

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[483] European Commission, *Proposal for a Decision on serious cross-border threats to health*, p. 23.
[484] *Regulation (EU) No 182/2011 of the European Parliament and of the Council of 16 February 2011 laying down the rules and general principles concerning mechanisms for control by Member States of the Commission's exercise of implementing powers.* OJ L 55/13, 28.2.2011.
[485] *Regulation (EU) No 182/2011 laying down the rules and general principles concerning mechanisms for control by Member States of the Commission's exercise of implementing powers.*

role in accordance with Articles 4 and 11 of the Proposal. The use of the word assist is of note here because it raises a point of ambiguity with respect to where the power of decision-making lies within the Committee – that is, whether the HSC is meant to be an organ of cooperation amongst the Member States and the Commission, or an organ of assistance to the Commission itself. If the case is the latter, then this suggests that the Commission would be positioned to play a much stronger decision-making role in matters that have up to this point been the responsibility of Member States. This would also suggest a much stronger role for the Commission in the implementation of Articles 4 and 11. Article 19 concerning the formalization and strengthening of the Health Security Committee, then, constituted another area where the Commission had the potential to strengthen its management role.

While the Articles on preparedness planning and coordination and response reasserted the central role of the Commission in coordinating health threats within the Union, Articles 12 and 13 focused on the capacity of the Commission to identify and respond to states of emergency. Article 13 concerned the recognition of emergency situations or of pandemic influenza situations and asserted a particularly strong role for the Commission as a securitizing actor. Paragraph 1 of Article 13 proposed to grant the Commission the means to formally recognise, through the use of implementing acts, '(a) situations of emergency at Union level; or (b) pre-pandemic situations with respect to human influenza at Union level.'[486] The implementing acts were to be adopted following the examination procedure referred to in Article 20(2) of the proposed Decision and outlined above.

[486] European Commission, *Proposal for a Decision on serious cross-border threats to health*, p. 24.

Significantly, the end of paragraph 1 of Article 13 also stated the following:

> On duly justified imperative grounds of urgency related to the severity of a serious cross-border threat to health or to the rapidity of its spread among Member States, the Commission may formally recognise situations of emergency at Union level or pre-pandemic situations with respect to human influenza at Union level through immediately applicable implementing acts in accordance with the urgency procedure referred to in Article 20(3).[487]

Article 20(3) of the proposed Decision referred to Article 8 of Regulation (EU) No 182/2011, which stipulated that 'on duly justified imperative grounds of urgency', the Commission could adopt implementing acts that have immediate effect without having to submit the proposed act to the committee – in this case, the Committee on serious cross-border health threats – beforehand.[488] Article 13 thus proposed to grant the Commission with the power to decide on the exception.

Paragraph 2 of Article 13 listed the conditions under which the Commission would be able to adopt the measures outlined in paragraph 1:

> (a) the Director-General of the World Health Organization has not yet adopted a decision declaring the existence of a public health emergency of international concern in accordance with Articles 12 and 49 of the International Health Regulations (2005);
>
> (b) the serious cross-border health threat at issue:
>
> (i) can, by reason of its nature, be prevented or treated by medicinal products;
>
> (ii) is rapidly spreading within and across the Member States and endangers public health at the Union level;

[487] European Commission, *Proposal for a Decision on serious cross-border threats to health*, p. 24.

[488] *Regulation (EU) No 182/2011 laying down the rules and general principles concerning mechanisms for control by Member States of the Commission's exercise of implementing powers.*

> (iii) is life-threatening;
>
> (c) the medicinal products, including vaccines, already authorised at Union level in accordance with Regulation (EC) No 726/2004 of the European Parliament and of the Council of 31 March 2004 laying down Community procedures for the authorisation and supervision of medicinal products for human and veterinary use and establishing a European Medicines Agency or in the Member States through the mutual recognition procedure or decentralized procedure referred to in Directive 2001/83/EC of the European Parliament and of the Council of 6 November 2001 on the Community code relating to medicinal products for human use, are not or may not be sufficiently efficient for the prevention or treatment of the threat concerned;
>
> (d) with a view to the formal recognition of a pre-pandemic situation with respect to human influenza at the Union level, the threat concerned is human influenza.[489]

Article 14 on the legal effects of the recognition stipulated that the recognition of an emergency situation or a pandemic influenza situation was to have 'the sole legal effect of triggering the applicability of Article 2(2) of Regulation (EC) No 507/2006' or in the case of a pandemic influenza situation, also Article 21 of Regulation (EC) No 1234/2008.[490] The former Regulation enabled the authorization of medicinal products to be used in emergency situations, while the latter granted the Commission the authority to 'exceptionally and temporarily accept a variation in the terms of a marketing authorisation for a human influenza vaccine, where certain non-clinical or clinical data are missing' in the instance where an influenza pandemic has been recognised by the WHO or by the framework for Decision 2119/98/EC.[491] Article 13, then, proposed to grant the Commission the capacity to declare a public

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[489] European Commission, *Proposal for a Decision on serious cross-border threats to health*, pp. 24-5.
[490] European Commission, *Proposal for a Decision on serious cross-border threats to health*, p. 25.
[491] *Commission Regulation (EC) No 507/2006 of 29 March 2006 on the conditional marketing authorisation for medicinal products for human use falling within the scope of Regulation (EC) No 726/2004 of the European Parliament and of the Council*. OJ L 92/6, 30.3.2006; *Commission Regulation (EC) No 1234/2008 of 24 November 2008 concerning the examination of variations to the terms of marketing authorisations for medicinal products for human use and veterinary medicinal products*. OJ J 334/7, 12.12.2008.

health emergency within the Union independent of the WHO for the purposes of fast-tracking the market authorization of medical countermeasures.

In addition to granting the Commission the capacity to identify emergency situations as stipulated in Article 13, the Commission's Proposal for a Decision also sought to grant the Commission the capacity to take common temporary public health measures – what can be considered for the purposes of this thesis as exceptional measures. Article 12 stated:

> 1. Where the coordination of national responses provided for in Article 11 proves insufficient to control the spread of a serious cross-border threat to health between the Member States or to the Union, and, as a consequence, the protection of the health of the population of the Union as a whole is jeopardised, the Commission may complement the action of the Member States through the adoption, by means of delegated acts in accordance with the procedure provided for in Article 22, of common temporary public health measures to be implemented by the Member States. These measures may not concern the control of the threat concerned within each Member State.
>
> 2. Paragraph 1 shall apply only to serious cross-border health threats which may result in deaths or hospitalisations on a large scale across the Member States.
>
> 3. The measures adopted under paragraph 1 shall:
>
>   (a) respect the responsibilities of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care;
>
>   (b) be proportionate to the public health risks related to that threat, avoiding in particular any unnecessary restriction to the free movement of persons, of goods and of services;
>
>   (c) be compatible with any applicable international obligation by the Union or of the Member States.[492]

[492] European Commission, *Proposal for a Decision on serious cross-border threats to health*, pp. 23-4.

Article 22 stated that a delegated act would enter into force immediately and would apply as long as no objection was expressed by the European Parliament or by the Council within the first two months of notification. In the case of objection, the Commission would repeal the act.[493] Taken together, Articles 12 and 13 not only sought to empower the Commission to identify moments of exception, but to also take exceptional action. The Commission thus sought to strengthen its position as a provider of health security within the Union through the proposed Decision.

The significance of the Commission's proposed Decision on serious cross-border threats to health for the process of securitizing pandemic influenza at the level of the EU, then, lies not only in its reassertion of the securityness of pandemic influenza and its formalization of EU level activities aimed at mitigating a pandemic eventuality, but also in the manner in which the recognised threat of an influenza pandemic has in itself provided the basis for both the expansion of the range of issues argued as constituting health threat and the expansion of EU-level competences and activities in managing cross-border health threats within the Union. Through the Proposal for a Decision on serious cross-border threats to health, the Commission has been able to assert a stronger role for itself and for the Union in managing cross-border health threats.

However while the process of securitizing pandemic influenza has reached a new stage in the form of institutionalizing arrangements to confront a pandemic eventuality, the precise role and extent of EU involvement in managing the threat of

[493] European Commission, *Proposal for a Decision on serious cross-border threats to health*, p. 29.

pandemic influenza and cross-border health threats more generally is, at the time of writing, still under negotiation. This process of negotiation not only underscores the inherently political nature of securitization, but also the relational power of the Commission, the Council and the Parliament in the securitization process itself. It is to this process of negotiation that attention now turns.

First reading of the Commission Proposal for a Decision on serious cross-border threats to health: The current state of play

While both the Council and the Parliament have welcomed the Commission Proposal for a Decision on serious cross-border threats to health, a number of aspects of the Proposal have raised concerns within the Council in particular. These concerns have included not only technical aspects regarding the scope of the proposed legislation and the procedures that are to be followed in implementing it, but also who is empowered to make key decisions. The Commission's Proposal for a Decision has thus brought to the fore an ongoing tension inherent to the process of securitizing pandemic influenza at EU level. This tension has concerned the extent of Community involvement in managing such cross-border health threats as an influenza pandemic.

In addition to the technical ambiguities concerning the role and composition of the Health Security Committee already mentioned, the stronger assertion on the part of the Commission of its role in managing cross-border threats to health, particularly as it relates to Articles 12 and 13, have provided the basis for extensive discussions amongst Member State representatives as to the position of the Council on the proposed Decision. At a Council meeting held from 21-22 June 2012, Health

Ministers held an orientation debate on the proposed Decision under the direction of the Danish Presidency and on the basis of discussions already undertaken by the Working Party on Public Health. While the Council agreed that the Health Security Committee should be given a legal basis and reasserted the importance of preparedness within the Union during the course of the debate, members of the Council agreed that preparedness was best achieved 'through coordination and the exchange of information between member states within the health security committee (HSC), rather than an obligation for prior consultations or recommendations by the Commission.'[494] On this point, members of the Council emphasized the need to ensure that national competencies in the field of health were respected.[495]

The Council also agreed during the course of the meeting to delete Article 12 from the Decision, thereby eliminating the possibility of the Commission adopting binding common temporary public health measures by delegated acts. Rather, the Council agreed that Member States should agree on such measures through the HSC.[496] The Commission opposed the deletion of Article 12 on the basis that common temporary public health measures 'would provide a safety net in case the coordination of national responses proves insufficient to cope with an extreme emergency situation and the protection of the population of the Union as a whole is thereby jeopardised.'[497] The Council met again on 6-7 December 2012 to discuss the

[494] Council of the European Union. *3177th Council Meeting: Employment, Social Policy, Health and Consumer Affairs*. 11386/12 (Presse 266). Luxembourg, 21-22 June 2012.
[495] Council of the European Union, *3177th Council Meeting.*
[496] Council of the European Union, *3177th Council Meeting.*
[497] Council of the European Union. *Employment, Social Policy, Health and Consumers Council meeting on 6 and 7 December 2012: Proposal for a Decision of the European Parliament and of the Council on*

Commission's Proposal, this time under the leadership of the Cyprus Presidency. In keeping with the previous discussion, the Council reasserted its position that the Decision should not infringe on the autonomy of Member States as it concerns preparedness planning and response, maintaining that the Commission's role 'should be restricted to supporting the creation and implementation of national plans.'[498]

On 17 October 2012, the European Parliament ENVI Committee tabled its report on the Commission Proposal for a Decision on serious cross-border threats to health before the European Parliament plenary session. The report broadly lent support to the Commission's Proposal, but recommended a series of amendments that reflected some of the concerns raised by the Parliament in the review of lessons learned from the 2009 influenza A(H1N1) pandemic. Amongst the amendments recommended included clarifications on the roles and responsibilities of actors and structures at EU level, along with the need to emphasize further the importance of a coordinated communication strategy.[499] The report argued, moreover, for the need to emphasize cooperation with such competent international organizations as the WHO throughout the Decision and maintained that an additional article on the independence and transparency of experts should be added to the proposed Decision.[500]

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serious cross-border threats to health (First reading) (Legislative deliberation) – Progress Report. 16570/12. Brussels, 3 December 2012, p. 2.

[498] European Public Health Alliance. *Council of the EU Discusses Serious Cross-Border Threats to Health*. Available from: http://www.epha.org/a/5489 [Accessed on 3 May 2013].

[499] European Parliament. *Report on the proposal for a decision of the European Parliament and of the Council on serious cross-border threats to health*. A7-03337/2012, 17.10.2012, pp. 14, 18, 23, 33.

[500] European Parliament, *Report on the proposal for a decision on serious cross-border threats to health*, p. 33.

On the basis of the concerns raised in the Council and in the European Parliament report, a compromise agreement on a revised Decision on serious cross-border threats to health was reached between the Council's Permanent Representative Committee and the European Parliament on 15 May 2013. The revised Decision maintained the following key elements: (1) the extension of the EU's existing legislative framework for health security to include a wider array of threats, including those of biological, chemical, environmental and unknown origin; (2) the formalization and strengthening of the Health Security Committee; (3) the provision of a legal basis for a voluntary joint procurement mechanism for pandemic vaccines; and (4) 'the possibility that the Commission recognises a situation of public health emergency for the purposes of conditional marketing authorisations for medicinal products and for derogations of the terms of a marketing authorisation for a human influenza vaccine' as a means of enabling the 'accelerated marketing of medicinal products or vaccines in an emergency situation.'[501]

The revised Decision, however, also reflected the concerns over competence raised by the Council. This included ensuring that Member States 'keep their autonomy with regard to preparedness and response planning, that preparedness planning should not be mandatory at European level and that the Commission's main role should be to support the actions by Member States.'[502] Moreover, this included ensuring that the Health Security Committee remained a consultative body amongst the Member States and the Commission alike. As such, the revised Article

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[501] Council of the European Union. *Cross-border health threats: Council confirms agreement with EP*. 9610/13 (OR.en) PRESSE 200. Brussels, 15 May 2013.

[502] Council of the European Union, *Proposal for a Decision of the European Parliament and of the Council on serious cross-border threats to health (First reading) (Legislative deliberation) – Progress Report*, p. 3.

19 stipulated that the HSC was to 'coordinate in liaison with' rather than 'assist' the Commission on preparedness and response planning as well as on risk and crisis communication and response to serious cross-border threats to health.[503] Article 12 was deleted from the revised Decision and Article 13 on the recognition of emergency situations was redrafted to read as follows:

> -1. The Commission may formally recognise a situation of public health emergency:
>
> (a) for situations of emergency concerning epidemics of human influenza considered as having pandemic potential, the Director-General of the World Health Organization has been informed and has not yet adopted a decision declaring a situation of pandemic influenza in accordance with the applicable rules of the World Health Organization;
>
> or
>
> (b) for situations of emergency other than those referred to in point (a), the Director-General of the World Health Organization has been informed and has not yet adopted a decision declaring a public health emergency of international concern in accordance with the International Health Regulations (2005);
>
> and when
>
> (i) the serious cross-border health threat at issue endangers public health at the Union level; and
>
> (ii) medical needs are unmet in relation to that threat, which means that no satisfactory method of diagnosis, prevention or treatment is authorised in the Union or, even if such method exists the authorization of a medicinal product could be of major therapeutic advantage to those affected.
>
> ....

[503] Council of the European Union. *Proposal for a Decision of the European Parliament and of the Council on serious cross-border threats to health – Outcome of the European Parliament's first reading (Strasbourg, 1 to 4 July 2013)*. 11666/13. Brussels, 5 July 2013, p. 56.

> On duly justified imperative grounds of urgency related to the severity of a serious cross-border threat to health or to the rapidity of its spread among Member States, the Commission may formally recognise situations of public health emergency pursuant to paragraph 1 through immediately applicable implementing acts in accordance with the urgency procedure referred to in Article 20(3).
>
> 3. The Commission shall inform the Director-General of the World Health Organization of the adoption of the measures referred to in paragraph 1.[504]

In keeping with the Commission's Proposal for a Decision, the legal effect of Article 13 was to enable the accelerated market authorization of medical countermeasures. On 13 July 2013, the European Parliament voted in favour of the revised Decision on serious cross-border threats to health based on the compromise agreement reached between the Council and the Parliament. The Council has yet to convene to vote on the revised Decision, but is expected to be in a position to approve the legislative act in accordance with the Parliament.

In a press release following the Parliament's approval of the redrafted legislative proposal, EU Commissioner for Health, Tonio Borg, stated that the vote 'mark[ed] a major milestone for health security in the EU.'[505] In his statement, Commissioner Borg reiterated the threat posed by emerging and resurgent infectious diseases that has dominated engagements with health security to date, citing the recent identification of the new avian influenza (H7N9) virus and of the

[504] Council of the European Union, *Proposal for a Decision of the European Parliament and of the Council on serious cross-border threats to health – Outcome of the European Parliament's first reading (Strasbourg, 1 to 4 July 2013)*, pp. 47-9.
[505] European Commission. *Health: Major step forward in tackling serious cross-border health threats – statement by Tonio Borg, Commissioner in charge of health*. MEMO 13/644. Strasbourg, 3 July 2013.

MERS-CoV virus as examples of the continued threat posed by the microbial world. Commissioner Borg stated:

> Many of us - citizens, health professionals, and policy makers alike, keep a watchful eye on emerging health threats – be they the new strain of avian influenza A (H7N9), the novel Middle East Respiratory Syndrome Coronavirus (MERS-CoV) or a foodborne disease such as an outbreak of e.Coli. In addition, slower spreading threats like antimicrobial resistance or the possibility to get an infection while in health care also represent a risk to citizens' health. EU citizens need to be assured that a robust and coordinated risk and crisis response is in place to protect them.
>
> That is precisely the aim of the Decision adopted today. People in Europe will be better protected from a wide range of health threats through strengthened preparedness planning and coordination at EU level for serious cross border threats caused by communicable diseases, chemical, biological and environmental events. One of the key achievements of the Decision is that it establishes the legal basis for the coordination of voluntary joint procurement of vaccines and medicines at EU level. We will start with the procurement of pandemic vaccines: the Member States who participate in this process will be able to provide their citizens with vaccines under better conditions than in the past.
>
> The Decision also boosts the European Union's authority in the event of a health emergency: It allows the EU to declare a health emergency within its territory to trigger measures under its pharmaceutical legislation so that vaccines and medicines can be provided faster. The clear mandate for the Health Security Committee to coordinate risk and crisis response, including communication, during a crisis, means that coordination of public health emergencies will be further improved.[506]

The Commission Proposal for a Decision on serious cross-border threats to health can thus be considered the next step in a securitization process already underway at EU level. By the end of 2011, with the introduction of the Commission Proposal for a Decision, the process of securitizing pandemic influenza had moved from a general

[506] European Commission, *Health: Major step forward in tackling serious cross-border health threats – statement by Tonio Borg, Commissioner in charge of health*.

recognition of the securityness of pandemic influenza as a threat subject, to the recognised need for formalized responses to it, to debates as to who, in the moment of emergency, is to provide for health security, under what conditions and following which procedures.

While the Council has yet to approve the redrafted Decision on serious cross-border threats to health, the revised Decision has asserted a distinct role for the EU as a health security actor and has strengthened the basis for the EU's health security framework to date. Article 13 of the revised Decision is of a particular note in this regard as it proposes to provide the Commission with the power to declare a public health emergency independent of the WHO as a means of activating the provision of pharmaceutical countermeasures within the Union. Nevertheless, the executive powers granted to the Commission in providing for health security remain limited. Article 12 on the implementation of binding common temporary public health measures has been deleted from the revised Decision altogether, while the rewording of the Articles concerning preparedness planning and the role and composition of the HSC have ensured that the Commission maintains primarily a coordinating role.

Indeed, the negotiations surrounding the proposed Decision on serious cross-border threats to health have brought to the fore a tension inherent to the securitization process itself between the Commission, the Council and to a lesser extent, the Parliament as to the level at which the threat of pandemic influenza should ultimately be managed – a tension that has been evidenced at various degrees throughout the securitization process to date. Thus, while the focus of this

thesis is on the securitization of pandemic influenza at the regional level, an important aspect of this story is the iterative relationship between the Commission and the Council in the process of securitization.

Despite the Commission's limited power vis-à-vis the Member States given the lack of executive authority of the Commission and the empowered position of the Council in the securitization process, the process of securitization has provided the Commission with the strategic means of advancing claims as to the need for additional Community competences in managing the threat of pandemic influenza and cross-border threats to health more generally. This has been exemplified in particular in the case of the Commission Proposal for a Decision on serious cross-border threats to health where the prior request from the Council for a Proposal provided the Commission with the platform to assert itself as a securitizing actor. While the European Parliament has generally supported the Commission in promoting a more centralised approach to the management of the threat of pandemic influenza in the Union, the Council has been reluctant to endorse measures that are perceived to encroach upon the competences of Member States despite the recognised added value of EU level cooperation and coordination in this domain. In fact, while pandemic influenza may have been securitized *within* individual Member States, as the 2008 and 2013 UK national risk registers and the 2013 French White Paper on Defence and National Security would suggest, this does not necessarily translate into a willingness to further centralize pandemic preparedness and response at Union level.

The outcome of this relationship has been a process of securitization that has been marked by negotiations over power at various stages in the securitization process itself – negotiations that have played out in the debates over the Commission Proposal for a Decision on serious cross-border threats to health. In the case of the proposed Decision, this negotiation over power has primarily been expressed over issues of competence, the Council favouring a more intergovernmental approach to EU level coordination, while the Commission has pushed for a more centralised one with the general support of the Parliament. This relationship between the Commission and the Council not only reinforces the necessary distinction between the recognised securityness of a particular issue and the collective willingness to act on a securitizing claim, but also reinforces the non-hierarchical relationship between actor and audience. Outcomes at various stages in the securitization process are not controlled by any one actor, but are subject to negotiation. Thus, while it is possible to say that the process of securitizing pandemic influenza has currently reached a heightened stage at the level of the EU, this process of securitization remains a political one and one marked by varying degrees of success at different stages throughout.

Conclusion

This chapter has focused on the Commission Proposal for a Decision on serious cross-border threats to health in light of the process of securitizing pandemic influenza outlined in previous chapters. The aim of the chapter has been to examine the Commission Proposal and the discussions that have emerged from it as a means

of evaluating the relative success of the process of securitizing pandemic influenza to date and the implications it carries for the provision of health security within the Union.

The chapter has argued that the Commission's proposed Decision holds bearing for the process of securitizing pandemic influenza at the level of the EU on three counts: First, it constitutes a direct response to the Council's earlier requests for a legislative proposal formalizing the EU's health security framework. Second, it was introduced following the experiences with the 2009 influenza A(H1N1) pandemic and the lessons learned from it. Third, the Commission Proposal followed the entering into force of the Lisbon Treaty and the enhanced role and responsibilities of the Commission provided by it. The Proposal for a Decision on serious cross-border threats to health thus provided the Commission with the platform to not only reassert the securityness of pandemic influenza, but to also assert a stronger role for itself in managing health threats in the Union.

The chapter has demonstrated, moreover, that the threat of pandemic influenza has provided a structural force for not only the expansion of Community activities in providing for health security, but also for the expansion of the array of issues recognised as constituting health threats. Health threats in the context of the proposal encompassed not only pandemic influenza and similar infectious disease threats with the potential to emerge and spread rapidly, but also 'threats of chemical, environmental, or unknown origin,' exemplified by the examples given of the volcanic ash cloud and toxic red sludge incidents of 2010 and the E. coli outbreak

in 2011.[507] That which is threatened is not just the health of EU citizens, but also the continued economic functioning of the Union as a whole.

The chapter has argued that the introduction of the Commission Proposal for a Decision on serious cross-border threats to health therefore marked a new stage in the process of securitizing pandemic influenza to date. With the introduction of the Commission Proposal, the securitization process had evolved from the recognised securityness of pandemic influenza, to the recognised need for formalized institutional arrangements to confront it, to debates as to who is to provide for health security within the Union, under what conditions, and following which procedures. The chapter has argued that this move towards the institutionalization of arrangements aimed at countering the threat of pandemic influenza and cross-border threats to health generally is a logical next step in an ongoing securitization process rather than being the outcome of a successful securitization per se. As such, the move to institutionalize arrangements at EU level remains political and subject to negotiation.

The negotiated nature of the process of securitization has been demonstrated in the examination of the debates surrounding the direction of the proposed Decision on serious cross-border threats to health. This has been exemplified in particular with respect to the disagreements between the Commission and the Council on Article 12 of the Commission's Proposal for a Decision on the implementation of common temporary public health measures, but has also been demonstrated by the debates over pandemic preparedness planning

[507] European Commission, *Proposal for a Decision on serious cross-border threats to health*, p. 2.

and the role of the HSC. Through the proposed Decision, the Commission has asserted a stronger role for itself as a health security provider and in so doing, has brought to the fore an inherent tension in the process of securitization between the Commission, the Council, and to a lesser extent, the Parliament as to the role and extent of Community involvement in the management of such cross-border health threats as an influenza pandemic – a tension that has been exhibited to various degrees throughout the securitization process to date.

This tension has not only underscored the importance of distinguishing between the recognised securityness of a particular issue and the collective willingness to act on a securitizing claim, but has also highlighted the importance of negotiations over power between the three institutions in the securitization process itself. Thus, while it remains possible to identify a process of securitization at EU level with political effect, this process of securitization has been met with only partial success to the extent that the Commission has convinced the Council and the Parliament to agree to some of the Commission's proposals but not others. As such, while it is possible to say that the securitization of pandemic influenza has reached a heightened stage at EU level, as demonstrated by the institutionalization of pandemic preparedness in the Union and the strengthened role of the EU in providing for health security, the executive authority granted to the Commission as a health security provider is likely to remain limited.

Conclusion: The securitization of pandemic influenza at the level of the EU: Outcomes and future research prospects

Introduction

The purpose of this thesis has been to interrogate the process of securitizing pandemic influenza at the level of the EU. The central research question informing the study has been: Has pandemic influenza been securitized at EU level? This has been followed by the subsequent question: What are the consequences for the role of the EU as a provider of health security?

The reason for asking these questions was two-fold: First, the securitization of disease has occupied a dominant position in engagements with the link between security and health to date, yet scholarship has only recently begun to empirically examine securitization theory's application to key case studies. Second, despite the growing role of the EU in the domain of public health, there has been little scholarly engagement with the EU's activities in this area, particularly as it concerns the securitization of health in this context. The aim of this thesis, then, has been to not only contribute to current understandings of the process of securitizing such cross-border health challenges as an influenza pandemic, but also to contribute to the literature on EU security governance by elucidating the role of the EU as a health security provider.

Securitization theory has provided the theoretical framework guiding the research project not only because of the predominant position that the theory has held in engagements with the link between security and health to date, but also because the theory provides an entry point into examining security dynamics at EU level in sectors other than the conventional areas of security and defence. Yet, as has been demonstrated throughout the body of the thesis, the Copenhagen School's theory of securitization does not provide the tools necessary to analyse securitizing processes as they pertain to pandemic influenza and the European Union.

Indeed, while the Copenhagen School's theory of securitization provides a theoretical means by which to begin to interrogate the constitution of pandemic influenza as a security threat, the empirical application of the theory to the case of pandemic influenza and the EU is unable to answer the central research question driving this thesis – namely, has pandemic influenza been securitized at the level of the EU? Crucially, the thesis has argued that this is not a consequence of the misapplication of the theory itself, but rather due to the assumptions underpinning the theory. In answering the central research question, then, the thesis has proceeded in two parts. First, the thesis has revisited the basic assumptions underlying the Copenhagen School's theory of securitization as a means of providing an account of securitization theory amenable to analysing securitizing dynamics as they pertain to pandemic influenza and the EU. Second, on the basis of this reworked theory, the thesis has sought to empirically account for the process of securitizing pandemic influenza at EU level.

Summary of key findings

The thesis began by introducing the revised theoretical framework guiding the empirical analysis. Chapter one argued that the root of the challenges posed in applying the Copenhagen School's theory of securitization to the case of the EU rests with the assumption of a domestic political context underpinning the theory. This assumption is made manifest not only in the criterion of exceptionality that creates a binary distinction between a politicized issue and a securitized one, but also in the hierarchical distinction between actor and audience. Taken together, these two factors presume a context not only where deliberation on political issues is possible, but also where political leaders have the competence needed to be able to declare the exception. As a consequence, the chapter argued, the Copenhagen School's securitization theory is faced with an inherent tension between the performative force of the security utterance and the external context in which the speech act takes place, making the theory difficult to apply to different empirical contexts.

As a means of overcoming this tension, chapter one argued for an externalist reading of securitization theory based on a revisiting of the interplay between the speech act, audience and context in determining security meaning. Securitization is thereby recognised as what Thierry Balzacq has defined as a 'strategic (pragmatic) practice' and focus falls on the use of persuasion to bring about the goals of a securitizing actor rather than the rules of the speech act articulation. In so doing, the significance of context is brought to the fore of analysis, both as it pertains to the role of external events and the contextually situated role of audience in determining

the success of a securitizing claim, and as it pertains to the parameters set on the possibilities of securitization by the institutional setting itself.

The thesis has thereby made the following three arguments based on a reworking of securitization theory: First, understood as an act of persuasion, the speech act is constituted on the one hand, by a logic of extreme or existential threat and on the other, by a priority for action. Exceptionality is context-bound and is determined not only in relation to the securitizing arguments and practices that are deployed to address a particular issue, but also in relation to the institutional setting itself and what is considered 'normal' in that setting. Second, external contextual developments play an important role in influencing the reception of securitizing claims made. Third, audience should be understood as an empowered one, existing prior to the speech act and carrying the capacity to influence the form, content and possible outcomes of a securitizing move. Audience acceptance of a securitizing claim can thereby be broken down into two parts: the acceptance of the securityness of a particular issue and the collective willingness to act on a securitizing claim in the way the securitizing actor is proposing. On the basis of this, the thesis has argued that securitization can be analysed as a two-part process, based on the interaction between discourse and practice over time.

The implications of this reconfiguration of securitization theory for the empirical analysis of the securitization of pandemic influenza at the level of the EU are three-fold: First, by placing emphasis on the intersubjective establishment of security meaning, securitization can be understood as a process rather than an event. As such, securitization is recognised as taking place over a longer temporal

trajectory than the moment and logic of the speech act itself and the dichotomy between politicization and securitization is broken down to expose the inherently political nature of securitization and the contestations over power that emerge from it. Securitization can thereby operate below the level of exceptionality and securitizing dynamics can be identified and examined at various stages in the securitization process itself.

Second, in recognising securitization as a process informed by context, securitization theory is opened up to empirical settings such as the EU where decision-making processes are likely to be more prolonged in nature and where the sovereign capacity to declare the exception does not exist. Third, by accounting for the role of external contextual developments in the securitization process, the significance of crisis events in influencing the strength of a securitizing claim is brought to the fore. This is not only relevant given the role that health crises have played in shaping international understandings of the security-health nexus to date, but also given the cyclical nature of pandemic influenza as a particular threat subject. Given pandemic influenza's historicity, the urgency attributed to the threat of an influenza pandemic is likely to be informed at least in part by external events.

On the basis of this revised approach to securitization theory, the remainder of the thesis sought to determine whether pandemic influenza has been securitized at the level of the EU. Chapter two provided an account of the broader contextual environment in which securitizing dynamics evidenced at EU level are situated. The chapter argued that over the course of the past 20 years, the link between health and (inter)national security has gained particular salience in the international

political arena, promoted on the one hand by actors for the strategic purpose of directing attention and resources to those health challenges with which they are concerned, and emerging on the other hand as a result of an increased sense of international vulnerability to disease emergence, particularly following such events as the 2001 anthrax attacks, the outbreak and spread of SARS in 2002-2003 and the emergence and resurgence of the H5N1 avian influenza virus. Health security in this context has predominantly been approached in conceptually narrow terms, focus falling on managing the disruptive force of highly virulent diseases on the economic and political stability of the state and the international system.

These international developments have had direct bearing on securitizing dynamics evidenced at the level of the EU. On this point, the chapter argued that the development of EU level competences in the domain of public health has been influenced by three factors: First, by a number of new health challenges that have arisen post-Cold War that have contributed to the growing preoccupation with the security risks associated with the microbial world; second, by the constellation of actors involved in promoting health security internationally; and third, by the EU integration project itself and the shift in the EU's role from primarily an economic entity to an increasingly political one. Health crises have played a fundamental role in instigating the creation of EU competences in the field of public health, the gradual formalization and enhancement of the Community's health protection role providing the backbone for Community action programmes and activities in this area and setting the parameters for the process of securitizing pandemic influenza at Union level. Health security in this context has reflected the predominant approach

to health security promoted internationally but applied to the specific regional context of the EU. As such, alongside protecting EU citizens from health threats, health security in the EU context has reflected a concern with protecting the economic and political integrity of the Union as a whole.

On this point, the chapter argued that the domain of public health has emerged as an additional site where the EU's evolving role as a security provider can be documented. A key feature of this evolving role has been the need for the EU to distinguish itself from other international actors in the field of public health. Moreover, given the close relationship between the evolution of an EU role in public health and the rise of health security internationally, it is clear that pandemic influenza had not been institutionalized as a security threat prior to EU engagement in the field of public health.

Against this backdrop, the remainder of the thesis focused on tracing the process of securitizing pandemic influenza at EU level. Chapter three focused on the period leading up to the outbreak of the 2009 A(H1N1) influenza pandemic, while chapter four focused on the 2009 outbreak event itself and its aftermath. The thesis argued that the unique institutional setting of the EU carries two consequences for the identification of securitizing dynamics at EU level. First, the EU polity is a decentralised and a fragmented one. Those actors involved in shaping the health security agenda are thus narrow and specialized, primarily made up of experts, bureaucrats and politicians from the field of public health itself. As a consequence of this specialized field of actors, a hierarchical distinction between actor and audience cannot be maintained. Moreover, the directional force between a particular

securitizing move, its reception and outcome cannot always be ascertained. Second, given the EU's limited social capital and its characteristically technocratic nature, a successful securitization in this context is not likely to be expressed by the breaking free of otherwise binding rules. Rather, the relative success of the process of securitization can be measured on the basis of the push for further EU-level competences and activities in governing the threat of an influenza pandemic.

On the basis of this and on the theory of securitization outlined at the beginning of the thesis, chapter three demonstrated that by examining patterns of securitizing rhetoric and practice over time, a process of securitization can be identified at EU level with political effect. By the end of 2008, pandemic influenza was not only recognised as a distinct threat subject, but the need for formalized arrangements at the level of the EU to counter the threat posed by an influenza pandemic was also recognised as necessary in response. This conclusion was drawn from the following key findings:

First, the process of securitizing pandemic influenza has been crisis-driven, informed by three crisis events in particular: the 2001 anthrax attacks; the outbreak of SARS in 2002-2003; and the resurgence of the avian H5N1 influenza virus in 2004-2005. These three events provided the basis for a series of securitizing claims and practices that instigated the push for further coordination at EU level in countering disease emergence. The enhancement of EU-level cooperative arrangements was thereby expressed through the following developments: (1) the creation of the Health Security Committee – an intergovernmental body charged with coordinating the response to pathogen emergence in the Union; (2) the establishment of the

European Centre for Disease Prevention and Control – a centralised EU agency responsible for risk assessment for the Union; and (3) a number of activities aimed at strengthening pandemic preparedness plans across the Union. These developments ultimately culminated in the request from the Council to the Commission for a legislative proposal formalizing the EU framework for health security.

Second, throughout this time period, it is possible to identify an ideational shift in thinking in the manner in which communicable diseases such as an influenza pandemic are recognised as issues to be acted upon. This was first evidenced by the Commission description of the anthrax attacks as a 'new type of threat', requiring plans 'which has so far been established to face threats from diseases.'[508] The period following the anthrax attacks also saw the introduction of the term health security to EU official discourse. This 'new threat' framing was reiterated in the Commission Proposal on the establishment of the ECDC, communicable diseases referred to as a new type of threat to both the lives of individuals and the economies of Member States that required advanced planning to mitigate.[509]

Within this time period, then, the possibility of communicable disease emergence was constituted as not just a source of vulnerability, but as a threat to EU citizens and the stability of the Union as a whole. Pandemic influenza was one example of this broader threat subject, but was also constituted as a threat in its own right, as indicated by the references to the devastation caused by the influenza

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[508] Commission of the European Communities, *Communication on Cooperation in the European Union on Preparedness and Response to Biological and Chemical Agent Attacks (Health Security)*, p. 4; Commission of the European Communities, *Civil Protection – State of preventive alert against possible emergencies*, 5.

[509] Commission of the European Communities, *Proposal for a Regulation Establishing a European Centre [for Disease Prevention and Control]*, pp. 3-4.

pandemic of 1918 and the need to prepare for the unpredictable, yet inevitable outbreak to come. The security logic informing this threat framing was based on an urgency for action premised on the need to prepare for an outbreak eventuality. The threat of communicable disease, moreover, was presented as a uniquely European problem, requiring EU-level action to confront. The chapter argued that the push for pandemic preparedness was also indicative of an ideational shift in thinking, marking a shift from a classic public health approach to disease circulation to a focus on the continued critical functioning of what Lakoff has identified as vital systems. The combination of this securitizing rhetoric and mobilization of activities at EU level in response is indicative of a process of securitization underway.

Building on the findings from chapter three, chapter four focused specifically on the outbreak of the influenza A(H1N1) pandemic in 2009 and its impact on the securitization process identified at EU level. The relevance of the 2009 influenza pandemic for the securitization of pandemic influenza at the level of the EU lies not only in the fact that it was the first pandemic event to test the strength of preparedness planning at EU level, but also in that the pandemic itself proved to be milder than initially anticipated and thereby held the potential to undermine securitizing efforts to date. The chapter demonstrated, however, that despite the ultimately mild nature of the 2009 influenza pandemic, the outbreak event did not undermine the process of securitization already documented, but rather reinforced it. This was in spite of the challenges in risk assessment, risk management and risk communication brought out by the crisis event itself. Rather, both throughout and beyond the pandemic period, EU actors continued to call for further coordination of

preparedness and response efforts at Union level, drawing on the challenges posed by the 2009 pandemic response as illustrations as to precisely why further coordinated EU level action was necessary.

The significance of these findings for the securitization of pandemic influenza at EU level is two-fold: First, they support the claim made in chapter one of the thesis that the materiality of threat plays an important role in the securitization process. In this instance, however, rather than reaffirm the threatening characteristics of an influenza pandemic made in previous securitizing claims, the relatively mild nature of the 2009 A(H1N1) influenza pandemic was viewed essentially as a lucky turn of events, ultimately providing an opportunity to strengthen preparedness and response efforts in the Union based on the shortcomings in responses to the 2009 influenza pandemic itself. The 2009 A(H1N1) influenza pandemic was thereby understood as a test case for the next pandemic to come, the outbreak serving as a strategic means of advancing claims for a stronger Community response and a stronger Commission role in combating cross-border threats to health independent of the threatening qualities of the event itself. The threat of an influenza pandemic, then, provided a structural force for further cooperation and coordination at Union level.

Second, on a related note, the continued prevalence of security discourse despite the relatively mild nature of the 2009 A(H1N1) influenza pandemic gives credence to the securitization process documented in chapter three of the thesis and to the strength of previous securitizing claims made. This suggests that by the

time of the 2009 influenza pandemic, the securityness of pandemic influenza was broadly acknowledged, although the means of response were still up for debate.

Chapter five focused on the Commission Proposal for a Decision on serious cross-border threats to health and current debates that have emerged from it. The chapter argued that by the time of the introduction of the Commission Proposal at the end of 2011, the securitization process had evolved from the recognition of pandemic influenza as a security threat, to the recognised need for institutionalized arrangements to address it, to current debates as to precisely how, in the moment of emergency, health security is to be provided. The aim of the Commission Proposal was to formalize institutional arrangements in addressing cross-border threats to health in the Union. In so doing, the Proposal expanded the scope of health security beyond a focus on communicable diseases and CBRN threats to include a broader array of incidents with potential public health consequences. Pandemic influenza was subsumed within a legislative framework that was broader in scope than communicable disease alone and provided the structural force not only for the expansion of EU competences and activities in providing for health security, but also for the expansion of the types of incidents recognised as health threats.

The chapter argued that this process of institutionalizing the threat of pandemic influenza provided a means of ensuring preparedness efforts are sustained in the absence of continued political priority and thereby constituted a next step in the ongoing securitization process. The Proposal, moreover, provided the Commission with the platform to assert itself as a securitizing actor by pushing for additional competences in providing for health security in the Union. This was

made particularly evident in the case of the proposed Article 12, which sought to grant the Commission the capacity to take common temporary public health measures and which the Council has subsequently decided to remove from the proposed Decision.

While the Commission Proposal is still undergoing its first reading at the time of writing, discussions to date over the content of the proposed Decision have highlighted a tension inherent to the process of securitizing pandemic influenza at EU level regarding the level at which the threat of pandemic should ultimately be managed. This tension was also made apparent in some of the empirical findings presented in chapter three of the thesis. Chapter three demonstrated that while the period leading up to the A(H1N1) influenza pandemic of 2009 resulted in the gradual expansion of community activities and competences in providing for health security in the Union, this period also exposed points of contention over the nature of EU involvement in managing such transboundary health issues as an influenza pandemic.

Three points of disagreement in particular illustrated the inherently political nature of the securitization process to date: (1) the unwillingness of the Council to alter the terms of the EU Solidarity Fund to encompass health crises; (2) the failure to establish an EU level stockpile of antivirals as part of the Union's pandemic preparedness efforts; and (3) the lack of authorization granted to the Commission to take emergency measures in the event of an influenza pandemic reaching EU borders. These points of disagreement were to some extent reflected in deliberations over the content of the proposed Decision on serious cross-border

threats to health. While the issue of stockpiling has not been revisited, the Commission Proposal did include an article on a voluntary joint procurement mechanism for influenza vaccines – a mechanism that has been viewed as favourable by both the Parliament and the Council following the experiences with the 2009 A(H1N1) influenza pandemic. However, as the discussions on the Commission's proposed Article 12 have demonstrated in particular, the extent to which the Council is willing to grant the Commission additional executive powers is limited.

Taken together, the findings presented in chapters three and four point to an implicit tension between the Commission and the Council and to a lesser extent, the Parliament over the process of communitarizing disease management and the competence that should be granted to the Commission in providing for health security within the Union. Moreover, the thesis has argued, they point to a process of securitization that has been marked not only by various degrees of success at different stages, but also by negotiations over power at various points throughout.

Outcomes and implications

On the basis of the findings presented throughout the body of the thesis, it is possible to conclude that pandemic influenza has been subject to securitization at the level of the EU. However, it is not possible to say that pandemic influenza has been definitively securitized. Rather, the thesis has demonstrated that the process of securitizing pandemic influenza has reached what can be considered a heightened stage. This is evidenced by the patterns of discourse and practice over time that have

resulted in the expansion of EU competences and activities in managing the threat of pandemic influenza through the creation of new tools and instruments at Union level. However, this process continues to be subject to negotiation and to date the securitization process has only been partially successful in granting the Commission additional executive authority in providing for health security within the Union. Importantly, this does not indicate a failure of securitization, but rather is indicative of the current stage in the securitization process itself. Arguably, moreover, it is indicative of the EU context itself and of what can be considered a general wariness over the extent of authority granted to the EU as a security actor by its Member States.

The implications of the research findings for the current state-of-the-art are three-fold and concern the contribution made to contemporary engagements with securitization theory, the insights gained into the securitization of pandemic influenza, and the contribution made to current understandings of the role of the EU in providing for health security. With respect to the first point, the thesis has contributed to the advancement of contemporary engagements with securitization theory by recognising securitization as processual and by exposing the contestations over power that emerge at various stages throughout the securitization process. This has enabled the theory to account for securitizations in the context of the EU where there is no centralization of authority and where the blurred distinction between actor and audience means that the securitization process and its outcome are not likely to be controlled by any one actor. However, this reworking of securitization theory is not limited to the EU itself and arguably provides a means of exposing

negotiations over various stages in the securitization process at both domestic levels and in other intergovernmental contexts. By recognising securitization as a process rather than an event marking a shift to a new level of operating, and by recognising audience acceptance as demarcated by stages, the inherently political nature of securitization is brought to the fore.

Moreover, the approach to securitization theory presented in this thesis provides a means of analysing the securitization of pandemic influenza in a manner that more accurately reflects the nature of pandemic influenza as a particular threat subject. Given the cyclical nature of a pandemic influenza, the process of securitization associated with it is also likely to be cyclical, marked by points of heightened and diminished sensitivity at different points in time. Measuring securitization in terms of patterns of discourse and practice over time and as marked by a distinction between the recognised securityness of a claim and the collective willingness to act on a claim provides a means of elucidating the degree of criticality associated with the threat at a given moment.

In the case of the EU, the process of securitizing pandemic influenza has been characterized by heightened points of attention and activity following crisis events. However, the cyclical nature of pandemic influenza and the recognised securityness of it have also enabled the threat of pandemic influenza to provide a structural force for the further expansion and consolidation of EU-level activities in the domain of public health. In this instance, pandemic influenza has not only been constituted as threat in its own right, but also as an example of a broader threat subject made up of health challenges with cross-border potential more generally. The role that the

anthrax attacks and SARS have played in the process of securitizing pandemic influenza, moreover, is indicative of the manner in which the securitization of pandemic influenza has also been situated within a broader process of the securitization of health.

Finally, securitization theory has provided a mechanism by which to account for the evolving role of the EU as a health security provider. On this point, the thesis has demonstrated that the domain of public health is another site where the EU's security actorness can be documented. The European Commission has played a key role in this securitization process, drawing on the language of security as a strategic means of gaining support for particular policies or activities, as made evident in the case of the establishment of the ECDC and in the push for additional competences in the Commission Proposal for a Decision on serious cross-border health threats. However, the points of disagreement that have emerged throughout this process have also revealed an inherent tension between a more intergovernmental approach to disease management in the Union, as generally favoured by the Council, and a more centralised approach, as generally supported by the Commission and the Parliament. These points of disagreement have highlighted the contestations over power in the securitization process itself. As a consequence, while the EU has gained increased competences in providing for health security within the Union, these competences remain limited.

Directions for future research

While the conclusions drawn from this thesis have contributed to current understandings of the securitization of such cross-border health challenges as pandemic influenza and of the evolving role of the EU in providing for health security, the limitations of this research point to three areas of future research potential. First, the focus of this thesis has been on the securitization of pandemic influenza at the level of the EU and the concomitant development of EU-level competences in countering an influenza pandemic. As such, analysis has fallen on the interaction between the three EU institutions in developing policy over time and not on developments within individual Member States themselves. One means of expanding on the research findings of this thesis would therefore be to examine in greater detail the interaction between securitizing dynamics and conditions within individual Member States and particular developments at the level of the EU. This would not only provide a means of elucidating the manner in which the differing capacities of Member States influence how securitizing dynamics are played out at the level of the EU, but also could potentially contribute to the further development of the theory of securitization outlined in this thesis by taking into account the interplay between the different levels of analysis in the securitization process itself.

Second, this thesis has focused exclusively on the role of the EU in providing for health security within the Union. However, as noted in chapter three of this thesis, the link between health and security has also been referenced in the EU's security strategies, while the Commission has expressed an explicit interest in

developing the role of the EU as an actor in the global public health arena.[510] An additional avenue for further research would therefore be to examine how the securitizing dynamics documented in this thesis have translated into EU action internationally. This would provide an additional indicator of the degree to which pandemic influenza – and health more broadly – has been securitized at EU level. It would also provide a means of exploring how EU engagements with health as a matter of security are situated alongside EU engagements with health as a matter of development, for example, and how these engagements interact with the EU's identity as an actor in the international arena.

Third, the theory of securitization outlined in this thesis has provided a means of examining securitizing dynamics in the unique institutional setting of the European Union. However, as has been noted in this thesis, the process of securitizing pandemic influenza at EU level has not grown in isolation of broader international engagements with the link between security and health. An additional means of developing the theory of securitization presented in this thesis would consequently be to test it in other intergovernmental contexts, whether regional organizations or intergovernmental bodies. In so doing, the theoretical contribution provided by this thesis could be applied beyond the EU setting itself and further developed to account for securitizing dynamics associated with other health challenges or other issues with cross-border potential.

[510] See European Commission, *The EU Role in Global Health*.

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